BIOTERRORISM RESEARCH AND POST-DEPLOYMENT HEALTH CARE FOR VETERANS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

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CONTENTS

March 27, 2003

Page

MATERIAL SUBMITTED FOR THE RECORD

BIOTERRORISM RESEARCH AND POST-DEPLOYMENT HEALTH CARE FOR VETERANS

THURSDAY, MARCH 27, 2003

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC

The subcommittee met, pursuant to notice, at 10:10 a.m., in room 344, Cannon House Office Building, Hon. Rob Simmons (chairman of the subcommittee) presiding.

Present: Representatives Simmons, Moran, Boozman, Bradley, Rodriguez, Snyder, Strickland, and Ryan.

OPENING STATEMENT OF CHAIRMAN SIMMONS

Mr. SIMMONS. The subcommittee will come to order.

I want to welcome my distinguished guests, and I will ask without objection that my full opening statement be inserted into the record, and hearing no objection, I believe it's done.

[The prepared statement of Chairman Simmons appears on p. 91.]

Mr. SIMMONS. There are two themes that we're going to be focusing on today.

One theme is how ready we are to deal with combat injuries and combat-related illnesses in the current war in Iraq? When we think of that theme, I think we think in terms of bioterrorism, chemical, biological injuries which fortunately I believe we have not experienced at this point in time, but certainly that is a concern that is on everybody's mind.

The second theme essentially is why Public Law 107–287 is not already funded and working to the benefit of future veterans and all Americans.

Returning briefly to the first theme, we're all concerned about our military forces serving so well in Iraq and also in the Philippines and Afghanistan, and our concern is that we protect that force.

The issues relative to force protection include medical surveillance, pre and post-deployment health assessment, environmental monitoring, security, vaccination, record keeping, protective and warning equipment, medical care in the theater, and then, of course, what happens when they rotate back to the States—what happens to those who have been exposed but don't show immediate signs of injury or illness, what happens to those who are actually injured and suffering.

From my own personal standpoint, my great uncle fought in World War I. He was gassed. That changed his whole life. It changed how he viewed his occupation. It changed where he lived. He moved to Colorado because the air and the altitude were considered beneficial to those who had been gassed.

These are important and critical issues.

The second theme dealing with Public Law 107–287, my distinguished chairman, Mr. Smith of New Jersey, and the distinguished ranking member from Illinois, Mr. Evans introduced this legislation. It passed through this committee in the House and Senate. It was signed into law.

But earlier this year, our dear friends in the Appropriations Committee saw fit to insert language into the omnibus bill that essentially said that no dollars in that omnibus appropriation would be used for this purpose.

That's an important issue for us to consider—why did that happen, what are we going to do about it, and what would be the impacts of not funding that legislation.

These are the two themes, as I see it.

What I plan to do today, with the agreement of my distinguished colleague from Texas, Mr. Rodriguez, is to offer to him, extend him the courtesy of an opening statement, and then go to the panel. Two of our panelists will be speaking, I believe, for 10 minutes each—and then following that, open it up to the committee for statements that they may wish to make and questions to the panel, and we'll just proceed in that process, if that's agreeable.

That being said, Mr. Rodriguez, do you have an opening statement you wish to offer for the record?

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Yes, sir, Mr. Chairman. Thank you very much.

Let me thank you first of all for allowing us this opportunity. I appreciate your calling this important and very timely hearing together.

With the troops in the field at the present time, it is critical for us to know that the infrastructure and the policies are in place to ensure that the health care services they need are readily available to them when they return back home, and I think that's important. I think we try to work at the VA to try to strike that balance there.

Sadly, many of us have already experienced war's devastating effects during the relatively brief time we've been engaged in Iraq. In my own district, I've been contacted from the Hernandez family from Mission in Elton Texas. Their son, Edgar, is a young soldier who is believed to one of the prisoners of war we've heard about during the week, and I will be praying for his safe return as quickly as possible.

We will hear today from the Assistant Secretary of Defense for Health Affairs, who will inform us of the many initiatives Congress approved as part of Public Law 105–85 almost 6 years ago, and are still "underway."

While there has been some progress since the first deployment to the Gulf, I am generally disappointed that so many of the promising tools the doctor's statements will reference are not going to

be available during this deployment; so these are areas that I think we need to continue to work on.

In addition, I believe there are major differences in expectations about how the Department of Defense is implementing various provisions which I am eager to hear about, and hopefully we will be able to dialogue.

We will also be hearing about the value of four medical emergency preparedness centers in the Department of Veterans Affairs Congress authorized under Public Law 107–287, and I believe that the VA proved its mettle in the wake of 9/11 after which it played a vital role in offering care, counseling, and referral services to those who were injured, the first responders, and victims' families members.

As the backup to the Department of Defense, and as part of the Federal Response Plan and National Disaster Medical System, the VA has a keen interest in helping our nation plan for the investigation in responding to the bioterrorism and defense practices in post-deployment care for our troops.

In this regard, I am proud of the work that has already been done, both in the San Antonio VA Medical Center, the Brooks City Base, and the University of Texas Health Science Center in my area, in San Antonio.

General Timboe is going to also talk to us and tell us more about the activities already being undertaken by the consortium and some of the unique resources they have at their disposal to advance the national research as well as the agenda for counter-terrorism efforts and for the planning to serve our veterans who return home ill after their services in the Gulf War.

Without stealing any of the thunder of the general, I just want to mention the joint Research Imaging Center with its state-of-the-art equipment, which is a cooperative venture between both the VA and DOD as well as the university, also the protein core facilities, and the advanced health care services offered by the VA and the Health Science Center, which I believe make it poised to make invaluable contributions in this area.

I know the general is a decorated combat veteran of both Vietnam and the Gulf War. He is actually a distinguished alumnus of the University of Texas Health Science Center at San Antonio and has held leadership positions at progressively more complex health systems throughout his career, ending his military career as the lead medical officer at one of the nation's military flagships here in our own back yard, at Walter Reed.

And so since July, the general has assumed responsibilities at the Health Science Center, which will include overseeing its involvement in homeland defense as well as bioterrorism research, and its partnerships with military medicine, including the VA, and I look forward to his testimony.

We are also, we are a nation at war, so we cannot afford not to take advantage of the very potent opportunity to advance our knowledge in addressing the bioterrorism and the health of our returning troops, and we really need to work in that area.

It's embarrassing, what happened after the Gulf War. We should not allow that to happen. It's embarrassing for us to hear that it took 20—30 years to hear about the Department of Defense on

those projects, 112. That should not be happening, and somehow we've got to make some inroads in terms of our nation and our dialogue in those specific areas; so as we move forward, I would look forward to your recommendations as to how we can expedite.

Our interest is to serve the veteran, and our interest is to be there in case of a—from a homeland defense perspective as one of our missions, as the first-time responders, to be there, not only for our veterans, but for our communities, so I look forward to working with you.

Thank you, Mr. Chairman.

[The prepared statement of Congressman Rodriguez appears on p. 95.]

Mr. SIMMONS. I thank the gentleman for his comment.

We will now go to the Department of Defense panel, the Honorable William Winkenwerder, Assistant Secretary of Defense for Health Affairs, accompanied by Dr. Michael Kilpatrick, Deputy Director of Deployment Health Support.

From the Veterans Administration we have the Honorable Dr. Robert Roswell, Under Secretary for Health, accompanied by Dr. Susan Mather, the VA's Chief Public Office and Environmental Hazards Officer.

Ladies and gentlemen, if you would proceed with your testimony, we will do the testimony from the panel and then have questions and answers afterwards.

Please proceed.

STATEMENTS OF WILLIAM WINKENWERDER, JR., M.D., MBA, ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, DEPARTMENT OF DEFENSE, ACCOMPANIED BY MICHAEL E. KILPATRICK, M.D., DEPUTY DIRECTOR, DEPLOYMENT HEALTH SUPPORT DIRECTORATE, OFFICE OF THE DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR FORCE HEALTH PROTECTION AND READINESS; AND HON. ROBERT H. ROSWELL, M.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY SUSAN MATHER, M.D., MPH, CHIEF OFFICER, PUBLIC HEALTH AND ENVIRONMENTAL HAZARDS

STATEMENT OF WILLIAM WINKENWERDER, JR.

Dr. WINKENWERDER. Mr. Chairman, members of the subcommittee, thank you for the opportunity to appear before you today.

With your permission, I'll summarize my written statement.

Mr. SIMMONS. Please.

Dr. WINKENWERDER. I want to begin by adding my condolences to those of President Bush and the Secretary of Defense for the families of those injured, captured, or who have died since operations began last week. Each of you is in our prayers.

Our country's ultimate weapon against any enemy is the valor of the men and women in our armed forces who serve the cause of freedom. They are the most powerful force on Earth, and in this case, a force for peace and liberation of the Iraqi people.

On behalf of all the men and women in the medical service to our armed forces, I want to recognize the cause for which they have

now given their lives and the efforts to ensure the safety of everyone engaged in this very difficult conflict.

The courage, skill, and discipline of our military medical personnel is matched only by the high quality, swift and effective medical care they provide. You've already seen reports by the embedded media of heroic acts, truly heroic acts by U.S. armed forces medics to save lives—for example, the rescue missions of forward surgical teams in medevac squadrons that have gone in, literally, to pluck people out of battle zones, stanch bleeding and injury, and get them back to safety, and save their life.

I think we can all be assured that such acts will continue until our final mission is accomplished.

In Operation Iraqi Freedom, we have more than sufficient capability to move casualties from their point of wounding to any level of care that might be required. We have more than sufficient medical supplies, including blood supplies, for all of our troops operating in the field.

I have the opportunity to review such reports on a daily basis. I can assure you I just reviewed one this morning, a couple of hours ago, and that is, in fact, the case.

Our medics and soldiers are trained, equipped, and prepared to operate in a contaminated environment if necessary, with equipment, decontamination materials, and medical antidotes. We are prepared for what Saddam Hussein might attempt to deliver to United States forces.

As the Assistant Secretary of Defense for Health Affairs, safeguarding the health and safety of our military members is my highest priority. Our Force Health Protection Program has made great strides, based on lessons learned from the Gulf War and subsequent deployments.

I believe our efforts are in line with your own objectives, as they have been expressed in public law. The Department is committed to provide an ongoing continuum of medical service to servicemembers, from their entry into the military through their separation, and as many transition to the Department of Veterans Affairs and its health care system.

The vigorous requirements of the entrance physical examinations, periodic physical examinations, periodic HIV testing, annual dental exams, routine physical training and period testing, and regular medical reviews are all parts of this continuum.

We have established a comprehensive program to document our servicemembers' health and fitness for duty.

All deploying personnel are required to complete individual predeployment health assessments. These health assessments are coupled with a review of medical and immunization records.

We look at whether there's a DNA sample on the record and if a blood serum sample has been drawn within the past 12 months. This information is considered, along with availability of personal protecting and medical equipment.

Pre-deployment briefings on deployment-specific health threats and counter-measures are also provided.

After deployment, all personnel must complete health assessments when they return, and we're looking at the possibility of actually doing those in theater, rather than when people get back, to

enhance the likelihood that that information gets completely collected.

Any indication of health concern results in an individual medical review by a physician, and if appropriate, referral for further medical evaluation or testing.

These health assessments are to be maintained in the individual's medical record and centrally, in electronic format, in our new Defense Medical Surveillance System.

Additionally, all immunizations are tracked by service-specific systems, and the data are fed into a department database. We're currently transitioning from paper-based medical records to automated medical records for patient encounters and for reporting of disease and non-battle injuries.

I'm pleased with the increasing level of cooperation that we've had between the Department of Defense and Veterans Affairs focused on post-deployment health concerns. Both military and veterans' medical providers are using today the jointly developed Post-Deployment Health Clinical Practice Guidelines. The guidelines were designed to ensure that providers do, in fact, render appropriate responses to the medical concerns of our deployed servicemembers and their families.

We've continued our cooperation in the area of physical examinations for veterans of all deployments. The Departments of Defense and Veterans Affairs are focused on continuing research to better understand and treat deployment health-related issues.

In DOD, we have established three Deployment Health Centers. One focuses on health care; one on health surveillance; and the third on health research. All are working towards prevention, treatment, and understanding of deployment-related health concerns; and the sharing of medical deployment data collected from individuals, units, and the environment will be of great value in providing optimal health to our deployed forces and those that return and become veterans.

Desert Shield/Desert Storm taught us that knowledge of the environment is important, and in fact, in some cases, maybe vital, if we're to protect the health of our servicemembers.

Today, the Army's Center for Health Promotion and Preventive Medicine—we call it CHPPM—conducts environmental testing that enables better assessment of the battlefield before and during deployments. They employ equipment to monitor the combat environment by sampling soil, air, and water.

We also archive that information so that we can go back and look at it later to evaluate for correlation between an area of known or suspected exposure or illness that may appear in the future.

In the past few months, the Department has developed and implemented a new system, Joint Medical Work Station. We're very excited about this, and we believe it has great promise.

DOD now has the electronic capability to capture and disseminate real-time and near real-time information to commanders in the field about in-theater medical data, patient status, environmental hazards, detected exposures, and critical logistics information like blood supply, beds, and equipment.

The transition from paper-based records to automated systems truly does offer us a much greater opportunity for collecting and

analyzing medical information in a common and systematic manner. However, we proceed with that work with an awareness of operational security and personal security for the servicemembers, who expect that their medical records will remain confidential.

When we deploy our forces, we bring a formidable medical capability. This includes far forward surgical care, medical evacuation assets, the ability to provide intensive care in the air, in the backs of airplanes—we'll talk about that—and ship-based medical care.

In the event of a biological or chemical attack, all services have made training improvements to assure that their medical personnel can successfully work in a contaminated environment and can decontaminate and rapidly evacuate their patients to safer environments.

Much has been accomplished in the past decade since the Gulf War. Our level of effort and our capability to protect our forces is unprecedented in military history. However, today we face new and deadly threats, and the possibility that a brutal regime would use chemical or biological weapons.

As military professionals and as health professionals, we're well aware that war means real risks, and that's particularly true in today's situation; but our message to you, to our servicemembers, to their families, and to the American people is that we are prepared, and we have extraordinary capability to protect and care for our people.

Mr. Chairman, I thank you again for inviting me here today. I'm pleased to be with Dr. Roswell, and I look forward to answering your questions.

[The prepared statement of Dr. Winkenwerder appears on p. 97.]

Mr. SIMMONS. Thank you. Dr. Roswell.

STATEMENT OF ROBERT H. ROSWELL

Dr. ROSWELL. Mr. Chairman, I'm pleased to be here today, also, and to testify before the subcommittee. As you've indicated, accompanying me is Dr. Susan Mather, who is our Chief Officer for Public Health and Environmental Hazards.

My full statement has been submitted for the record, but I would like to summarize the main points, beginning with the implementation of Public Law 107–287.

Regrettably, the implementation has progressed more slowly than anticipated, due to uncertainty about available funding. However, VA is actively pursuing implementation where possible.

Section 2 of Public Law 107–287 authorizes VA to establish four medical emergency preparedness centers. Although VA's Appropriations Act specifically prohibits any fiscal year 2003 funds from being spent on these centers. We have developed a detailed plan that we will implement upon the receipt of appropriated funds.

Section 3 requires VA to carry out a program to develop and disseminate a series of education and training programs on the medical responses to the consequences of terrorist activities. The programs are to be modeled after programs established at DOD's Uniformed Services University of the Health Sciences.

We've met with representatives of USUHS to explore collaborative endeavors and we will assemble a committee of experts to further address priority educational needs.

In the meantime, though, we've already developed and disseminated within VA a number of educational tools covering many of the issues specified.

Section 4 authorizes VA to furnish health care to persons responding to, involved in, or otherwise affected by major disasters and medical emergencies. As you are aware, VA's fourth mission is to serve as a principal health care backup to DOD in the event of war or national emergency.

Under activation of the VA/DOD Contingency Hospital System, VA will provide DOD with up to 4,600 beds within 72 hours, and more if needed beyond that time frame.

Care may also be provided at civilian hospitals enrolled in the National Disaster Medical System when DOD and VA health care facilities reach full capacity.

Regarding Section 5, VA has undertaken activities to ensure the protection of VA facilities, employees, and patients. VA has conducted numerous studies of security vulnerabilities and police officer staffing needs, and as taking appropriate actions based on these findings.

Section 6 codified already existing authorities that focus on VA's ability to respond to a terrorist attack involving the use of weapons of mass destruction.

VA has developed policies and strategies that address the appropriate response to such an attack, including an extensive system to deploy, track, and restock pharmaceutical caches, establishment of decontamination capabilities, accreditation of personal protective equipment, and strategies for providing mental health counseling and assistance.

I would now like to turn my attention to the VA/DOD efforts to coordinate force protection.

Let me begin by pointing out that VA is authorized to provide health care for 2 years following release from active duty after service in a combat zone.

With nearly 250,000 or more than 250,000 U.S. troops now engaged in a renewed conflict in the Gulf Region, VA today is better prepared to provide high-quality health care and disability assistance than at any other time in history. Since Operation Desert Shield/Desert Storm in 1991, a number of improvements have been put in place to allow us to better meet the health care needs of these veterans.

VA has implemented an innovative new approach to health care, known as the Veterans Health Initiative. This is a comprehensive program designed to increase recognition of the connection between military service and various health consequences. It better veterans' military exposure and histories, it improves patient care, and it will help us establish a database for further study.

The VA Health Initiative is available in monograph form on the web, as well as on compact disk.

In 2002, VA established two War-Related Illness and Injury Study Centers to provide specialized health care for veterans from all combat and peacekeeping missions who suffered disabling but difficult-to-diagnose illnesses. These centers also provide research into better treatments and diagnoses, and develop education programs for health care providers.

The Gulf War made clear the value of timely and reliable information about wartime health risk. VA has already developed a brochure that addresses the main health concerns for military service in Afghanistan and is preparing a second brochure for the current conflict in the Gulf Region.

VA's health care databases allow us to evaluate the health care status and utilization of veterans every time they obtain care from the VA.

Newly developed clinical practice guidelines that Dr. Winkenwerder already mentioned are based on the best scientifically supported practice and give health care providers the needed structure, clinical tools, and educational resources that allow them to diagnose and manage patients with deployment health-related concerns.

It's our goal that all veterans who come to VA will find their doctors to be well informed about specific deployments and the related health hazards.

We're also working with DOD to improve care and inter-agency coordination of health information.

In fiscal year 2002, a special Deployment Health Working Group of the VA/DOD Health Executive Council was established to ensure inter-agency coordination for all veteran and military deployment health issues. This group continues the work begun by the Persian Gulf Veterans Coordinating Board and the Military and Veterans Health Coordinating Board.

VA and DOD are collaborating on several important health information applications that will permit the departments to offer a seamless electronic medical record. Key initiatives around the Federal Health Information Exchange and the Health People Federal System.

Mr. Chairman, a veteran separating from military service and seeking health care today will have the benefit of VA's decade-long experience with Gulf War health issues, but the real key to addressing the long-term needs of veterans is improved medical recordkeeping and environmental surveillance.

For VA to provide optimal health care and disability assistance after the current conflict with Iraq, we will need the following:

First, a complete roster of veterans who served in designated combat zones.

Second, data from any pre-deployment, deployment, or post-deployment health evaluation and screening.

Furthermore, in the event that Iraq should choose to use weapons of mass destruction, it will be vital that VA have as much information, and environmental information and facts, as well as health information as is possible on the potential exposures and their health effects

This information will allow us to provide appropriate health care and disability compensation for veterans of this conflict.

Mr. Chairman, that concludes my statement. Certainly, Dr. Mather and I will be happy to answer any questions you or the committee may have.

[The prepared statement of Dr. Roswell appears on p. 103.]

Mr. SIMMONS. Thank you. I have a couple of questions.

I perceive that the Department of Defense and the Veterans Administration are, in a sense, in a catch–22 situation.

This subcommittee, under the able leadership of Vice Chairman Moran in the last session, was involved in hearings on this subject. The full committee, under the leadership of Chairman Smith and Ranking Member Evans passed legislation which went through the process, and was signed into law.

When it came to the appropriations process, which involves our colleagues, of course, on both sides of the aisle, language was inserted to prevent dollars from being used in the fiscal year 2003 budget; so, in a way, we've met the enemy and the enemy is us, not you.

That being said, though, the issue continues to be an important one, and I'd like to put a couple of questions to the panel to answer as they see fit.

If the assumption being made here is that we won't fund in 2003 because there is a better location for these dollars to go rather than the Veterans Administration, my question would be, if we're not going to fund these centers through the Veterans Administration, if this is not the appropriate place for these dollars to go, where are they going to go?

If it's going to go to the Department of Homeland Security, who is going to do this work in the Department of Homeland Security, and when is it going to be done, and where is it going to be done, if, in fact, that is the correct assumption or the correct hypothesis.

I would ask both of the witnesses, does not the VA have a longstanding history of competence in this kind of work, working closely with the Department of Defense? Is not the VA the recipient of, I think, three Nobel Prizes in medicine, for example, and numerous other prizes for excellence in education? Who else is out there that I don't know about that is going to assume this responsibility?

If you could respond, I'd appreciate it.

Dr. ROSWELL. Mr. Chairman, I certainly agree that VA has a long and well-established track record in medical research. With over $400 million in intramural funds and more than twice that amount in extramural funds, our total funded research portfolio within the Department exceeds $1 billion a year.

VA currently has affiliations with 107 of America's medical schools, and those affiliations have allowed us to provide cutting-edge, state-of-the-art care. That academic affiliation, coupled with over 1,300 locations of care, a provider force that includes over 15,000 physicians and 65,000 nurses, makes VA an ideally situated health care system to pursue a mission, should the appropriations be made available.

Mr. SIMMONS. Any comment from the DOD?

Dr. WINKENWERDER. Yes. I would just say that DOD recognizes VA's obvious outstanding contributions to research, and especially as that relates to deployment health and weapons of mass destruction, and the longstanding role they have had, as Dr. Roswell describes, working with academic medical centers across the United States.

The administration, as I understand it, views the Department of Homeland Security as the place that these funds might be transferred to.

I think it does present a challenging situation for them, without the assets in place to do this work. I'm not familiar with the plans that are in place to actually move forward in an expeditious manner.

So it certainly is a challenging situation, but we're staying ready to work together with whomever becomes the source of this funding, and we obviously will continue to work very closely with the VA under any scenario.

Mr. SIMMONS. I appreciate those responses; and again, it is a catch–22. It's the Congress dealing with the Congress in a way.

But if the dollars, the appropriated dollars go to the Department of Homeland Security, then are they going to replicate or create their own capacities here? Are they going to transfer those dollars perhaps to VA to do the job? Has VA been in touch with Secretary Ridge to see if he has anything in his budget to cover this in the fiscal year 2003 time frame?

Dr. Roswell.

Dr. ROSWELL. I certainly couldn't speak on behalf of DHS. We have had an active dialogue with DHS staff concerning our role, but to my knowledge, this specific issue of the emergency preparedness centers has not come up in any of the discussions, at least that I've been involved with.

Mr. SIMMONS. I thank you. I'll yield back my time. Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you. I'll take some of your time, also. Thank you.

Let me first of all thank both of you for being here.

Let me ask the Department of Defense, do you all have a single database? You know, one of the biggest problems we have, for example, with the INS is that they have, I've been told they have five different databases. They can't talk to each other or anything. Have you even looked at that? Do we have one single database, when it comes to health?

Dr. WINKENWERDER. We have a single medical record system, the CHCS–2.

Dr. ROSWELL. And it goes across the Army, the Navy, and everyone?

Dr. WINKENWERDER. It does, for what we call Continental United States routine, everyday medical care.

In the deployed situation, each of the services has a system that collects information. A surveillance system is the term we use to describe it, but in fact, it collects the kinds of information that would be collected in a routine medical visit.

Until about 6 months ago, those systems existed separately. We undertook an effort to bring them together to create a central database, such that a commander in the CENTCOM area, General Franks or one of his subordinates, and actually on up the line to here—I can view this information—can view it every day on a real-time basis. That gives an ability to surveil across all our forces.

Now, this system, because it is work that might have taken 3 years or 4 years, and we've done it in 3 or 4 months, which is a miraculous effort, it is still being implemented.

Mr. RODRIGUEZ. Okay.

Dr. WINKENWERDER. So it's not 100 percent. It's rapidly moving into the field——

Mr. RODRIGUEZ. Yes, because I would think——

Dr. WINKENWERDER. I can tell you that we have shared this information with the senior leadership in the Department, including Secretary Rumsfeld, and he is giving his strong encouragement to move this as quickly as possible, and in fact, we're doing that.

Mr. RODRIGUEZ. Yes, because I know that sometimes, with bureaucrats, we'll say we've done it, but I know how long it takes for staff to actually get involved and try to change from one data system to another; so I think that that's going to be very important.

Let me ask you also, Dr. Roswell talked about the fact of some of the needs that they're going to require for the veterans, and lists, and he mentioned that if our soldiers are out there in the area of bio and chemical and get exposed to that, it is going to be very important for them to know, for the benefits and for the impact.

Were you listening to those comments, and are we going to be able to kind of work with you to make that happen?

Dr. WINKENWERDER. Was your question to me?

Mr. RODRIGUEZ. Yes, to the Department of Defense.

Dr. Roswell mentioned a little litany of things that the VA needs to help our veterans.

Dr. WINKENWERDER. Yes.

Mr. RODRIGUEZ. One of those was, if we get—and I know some of that might be classified initially, but at some point, we got to know if the Iraqis use chemical and biological, and if they do, I don't want to hear, 10, 20 years from now——

Dr. WINKENWERDER. Right.

Mr. RODRIGUEZ (continuing). Like with the Gulf War, that, you know, unless we're naive and don't know what the hell is going on——

Dr. WINKENWERDER. Exactly. We, I think, all together share the concern to have accurate, well-collected information that is available to the Veterans Administration as soon as possible after our servicemembers are terminated from service.

Obviously, for us to be able to do that, we have to collect that information in a comprehensive and systematic way, and that is what we're committed to doing.

We're also committed to getting that information to the VA, and I've talked with Dr. Roswell about this, as quickly as possible.

My personal view is that in the prior war situation, in the Gulf War, that it took too long to get that information transferred, and part of that was a reflection of the less-than-optimal collection of data and recordkeeping that the DOD did at that time. I believe we're in much better shape, but I can tell you that we're continuously monitoring this situation.

Mr. RODRIGUEZ. In addition to collecting it, I think the other thing is the willingness to communicate.

Dr. WINKENWERDER. Yes.

Mr. RODRIGUEZ. And I think that's going to be very important, and I can understand there are certain areas you might not be able to communicate because of a national defense perspective or whatever, but in certain areas I think you can release, you know, and

be able to, if there are certain things that we feel that there might be some biological or chemicals that were utilized in a certain area of Iraq, that, you know, to know that is extremely important for our veterans as they get released, so that's going to be very important.

Dr. WINKENWERDER. I agree with that, and as I said in a hearing earlier this week, I think from my perspective the more we can get accurate information out soon, the better everyone's interests are served.

Certainly, that's true for the servicemembers. It's true for medical providers. I think it's true for all of us. We're best off to know what we've dealt with, and to get it out there and to respond to it.

So I am very committed to getting that done.

Mr. RODRIGUEZ. And in some cases, we've got to get that information as quickly as possible, even prior; because I heard you say when they leave. We almost need it, if it doesn't impact the war scenario, then, you know, when it happens, even if they're still, you know, in the military——

Dr. WINKENWERDER. We will collect it at that point. We do have an issue with transferring that information to the Veterans Administration or, really, to anybody, until the servicemember is separated.

Mr. RODRIGUEZ. I understand that, on an individual basis, but if you know it was used in a certain city or a certain—you know, without mentioning names, it can be extremely helpful to us.

Dr. WINKENWERDER. I think aggregate information, yes; but individuals, we can't share because of privacy concerns.

Mr. RODRIGUEZ. Thank you very much.

Dr. WINKENWERDER. Yes.

Mr. SIMMONS. Next, we have the vice chairman, Mr. Moran, followed by Dr. Snyder.

OPENING STATEMENT OF HON. JERRY MORAN

Mr. MORAN. Mr. Chairman, thank you very much. I commend you and Mr. Rodriguez for your continuing interest in this topic.

This subcommittee, shortly after our deployment in Afghanistan, more than a year-and-a-half ago, began an inquiry into the preparedness of both the Department of Defense and the Department of Veterans Affairs, and what at least initially seemed to me to be an important focus for us was what did we learn in the Persian Gulf War that is applicable to the circumstances that our men and women of the United States military would face in the Middle East should they be deployed again.

Certainly with those service men and women now serving in Iraq and Kuwait and the surrounding area, this topic is an awfully important one.

The overall goal that I think we ought to have is that we learned statement from the Persian Gulf War, we learned what was the cause of more than 100,000 service men and women complaining of Persian Gulf War Syndrome; and what steps have we taken to reduce the likelihood that our military personnel return home after this engagement—initially Afghanistan and now Iraq—without suffering those same kinds of consequences?

This subcommittee held a series of hearings, including one jointly with a subcommittee, the Personnel Subcommittee, with the Armed Services Committee here in the House.

I journeyed to Afghanistan last August and viewed personally the military hospitals, the ships, the Navy hospitals, and talked to personnel regarding this issue.

I guess my initial question is perhaps to—and I appreciate the doctors being here. All four of you have been through this topic with us in the past, and I appreciate your interest. It seems to me we certainly have the goal of the health and safety of the men and women of the United States military as a common goal.

What specifically are the things that we have learned from those veterans returning home from the Persian Gulf War complaining of illness, that we now believe we will be able to eliminate the likelihood of those similar complaints today?

Dr. WINKENWERDER. I believe we have learned some lessons in terms of actually preventing illness, and——

Mr. MORAN. And doctor, I appreciate you focusing on prevention, because a lot of what we've talked about over the last year-and-a-half has been recordkeeping and pre-deployment physicals, post-deployment physicals.

I think that's very important, but I think the initial question is, what do we do to avoid contact with the cause, the agents that may cause Persian Gulf Syndrome in the first place?

Dr. WINKENWERDER. Well, there's much, I believe, that we've learned.

One of the things relates to knowledge of what is on the battlefield or the battlefield space, so that environmental surveillance information such that certain exposures might be avoided—I think that's one thing we've learned.

A second would be in the area of chemical detection. I believe our chemical detection capability is much improved, and so that if we're moving into an area, our knowledge about what might be there is better so that people can then don protective equipment and reduce the chance that they might be exposed. That's a second lesson learned that might protect.

I think that a third area relates possibly to the use of pesticides, in reducing the amount of pesticide use and better controlling it and keeping better records and giving guidance to soldiers about not wearing certain kinds of things, like flea collars and things like that, that all of that—I think those are three important areas.

I would add to that, maybe with respect to the pyridostigmine bromide tablets, even though they are FDA approved and even though that's a drug that's used to treat illness, that's thought to be and I believe is safe and effective, that it ought to be used carefully and with good guidance and instruction and recordkeeping, so that—and prior guidance about how to use that.

So I that those are four ways, hopefully, that could significantly reduce some of the unexplained symptoms that we saw in the past.

Mr. MORAN. Do our service men and women have different equipment today than they did 10 years ago, and are they operating under different policies as to when that equipment to protect them is to be used?

Dr. WINKENWERDER. Yes. The J-list suits are different chemical protective over—chemical and biological—and the mask is new, as well, yes. So——

Mr. MORAN. Do we have any evidence that our service men and women have come in contact with chemical or biological weapons since the beginning of our ground activities in Iraq?

Dr. WINKENWERDER. I am not aware of any such exposure at this time.

Mr. MORAN. And anything we've learned in this last week that—I mean, are you looking at this on a day-to-day basis?

Dr. WINKENWERDER. Absolutely; and I think the most relevant information we've learned just yesterday, or it would have been the last 24 to 36 hours, related to the discovery of chemical protective suits and chemical antidotes, et cetera, that suggested to me, certainly, that the Iraqis are prepared to protect themselves, and since they know that we don't use those weapons, I can only assume that it would be because they would want to protect themselves against their own use of those weapons.

Mr. MORAN. Thank you very much, doctor. Thank you, Mr. Chairman.

Mr. SIMMONS. I thank the gentleman.

Dr. Snyder followed by Mr. Boozman.

OPENING STATEMENT OF HON. VIC SNYDER

Dr. SNYDER. Thank you, Mr. Chairman.

Mr. Chairman, I don't think I'm going to ask any questions, but I just want to make a comment that, and I know from our service together on multiple committees that you'll have an appreciation for what I say.

I think this is an excellent discussion. We may want to consider having a closed hearing on this topic with these people and some others. Some of the things I want to ask about—you know, I'll give you some examples here in a minute—I frankly don't want them to answer if there are problems.

For example—and we can all come up with our own scenarios here—we make a distinction between deployed and not deployed, but rapidly, this may well break down with a bio-attack.

We could transfer, for example, 100 wounded back to the United States, one of them, for whatever reason, their smallpox vaccine didn't work, and they're the vector for introduction into our military health care system or a veterans' health care system, or our private health care system.

We could have a situation where, in fact, the bio-attack is in the military base or military bases here in the States, which creates great disruption and morale problems for our troops overseas.

We could have a situation similar to the attack on Senator Daschle's office or the Post Office, where—this is just, you know, making up stuff like we all have for the last couple of years—where someone introduces, I don't know, cipro-resistant anthrax to Bethesda and Walter Reed.

We could have a situation where—I think in my district I have about 65,000 veterans—where the recommendation comes out, because of something going on, that everyone needs to be on cipro or

everyone need to be smallpoxed, and all our veterans head for our VA facility.

Are we prepared to respond to 65,000 veterans showing up at the emergency room within 48 hours?

Those, I think, are some of the discussions I would like to have, and the only reason I would want to have them is, I would want you all to point out where there are gaps, and specifically who outside—you know, I think we're having some evidence you all are having problems communicating with yourself, but in the scenarios I outlined, there would have to be multiple free exchanges of information and coordination with multiple agencies, both state and local, and federal, because you are not an isolated system, either within the states or internationally.

So I—you know, if anyone has any comment, feel free to make a comment, but we may want to consider, if we're going to pursue this topic, I think there are some lines of questioning that probably might be best in a closed hearing.

Thank you. Thank you, Mr. Chairman.

Mr. SIMMONS. I thank the gentleman. His point is well taken. In fact, I discussed with Panel 1 before the hearing the fact that, in the past, the hearing was behind closed doors for security purposes.

I believe the ranking member would be happy to join me in sponsoring an information session or a closed hearing for the members on that subject. As the former staff director of the Senate Intelligence Committee, virtually all of our hearings were closed, so I'm accustomed with that.

But I will also say that I think it's extremely important for people to hear what our members have to say, such as you, Dr. Snyder, on this issue, and to hypothesize the concern, because in hypothesizing the concern, we lay out scenarios that are real scenarios that we're concerned about, and scenarios that the American people should know about, because it's their tax dollars that are going to pay for the programs that address these scenarios.

So just what you've said in a few minutes about your concern I think is important for all Americans to know, and if it comes to a point where we need a very specific response or we need to identify some of our greatest vulnerabilities, then yes, I think we should go into closed session for that purpose.

So I thank you for your comments. Mr. Boozman.

Mr. BOOZMAN. I just want to echo, I think Dr. Snyder really raised some very valid points, not only for what we're going through now, but in the world that we live in, you know, this scenario could happen at any time, from now on.

One thing in Mr. Moran's questioning, you brought out that you thought that our chemical detection was better than it used to be.

Can you elaborate? How do we do that now? If you can—I mean, if we're in an area—do we have—do we wear patches, are there devices that glow? I know we don't have the parakeet in the mine, but what's the equivalent to that?

Dr. WINKENWERDER. Yeah. I will speak about this in a general way, for two reasons.

One, because it would be best not to get in detail in a public session, one; and two, because this is an area that's not directly, to

be clear, under my area of responsibility. It falls within the area of the Chemical, Biological, and Radio-Nuclear Program.

That program has under it the Army as the executive agent, and so they purchase all the chemical and biological protective equipment and detection. That falls under Dr. Anna Johnson Winegar. We work very closely together. I'm more concerned with the medical countermeasures. She deals with both, but deals more specifically with the non-medical pieces.

I would just say that, from my discussions with her and with others, that the sensitivity and specificity of the detection devices is improved. They detect more agents and there are more different ways that they can be deployed, not just standup, but handheld, and different kinds of ways that they can be used.

So, given the variety of situations that people find themselves in, there needs to be flexibility to that detection capability.

Mr. SIMMONS. Thank you, Mr. Boozman. Next is Mr. Strickland.

OPENING STATEMENT OF HON. TED STRICKLAND

Mr. STRICKLAND. Thank you, Mr. Chairman.

Dr. Kilpatrick, or others on the panel, as I've attended the briefings about the current situation, it seems to me that the response to questions has more often than not been a positive response, an optimistic kind of response to problems that may exist, but there is something that's just kind of been gnawing at me since I attended an unclassified briefing a couple of months ago, at which time a GAO report was made available to us regarding the protective garb that is available to our troops.

So I just have a number of questions relating to that, because watching the news reports, we're being told that there is expectation, perhaps, that at a certain point in this current operation, that our troops may be exposed to chemical weapons.

The question I have is about the quality of the protective gear, questions about whether or not the training in the use of that gear has been consistent. I've heard that in some cases the training has consisted of actually using the garb, you know, trying it on in a practice kind of way; in other cases, the training has consisted of little more than maybe watching a videotape.

Do we have adequate numbers, not just for any initial exposure, but if there are—if the war drags on and there are numerous exposures, do we have sufficient garments?

And then there was the discussion regarding the fact that there could be up to a quarter of a million defective garments that have been unaccounted for. We don't know if they have been destroyed or if they're in some inventory somewhere.

So I'm just wondering if you could—if one of more of you could just speak to that range of questions, and if it's something that you don't feel comfortable in talking about specifically here, I would understand that; but this has been something that has been of concern to me.

Dr. WINKENWERDER. Let me try to answer your question, because it's a very important question.

I'll start by saying again that this particular area is not directly under my responsibility, but I don't want to put you off and now

try to answer you, because I'm here and I represent the Department of Defense.

Again, these issues fall within Dr. Johnson Winegar's responsibility, but again, I'm in regular communication with her, so I'll tell you what I hear from her.

That is that the quality of the new J-list suits is very good, and we have a high level of confidence about the ability of those suits to protect people.

With respect to the numbers of them, and are there adequate numbers, I'm told that currently people have at least two, many people already have three, and within a matter of 3 or 4 days, everyone that's there will have three, so—and given the time frame that these are expected to be fully protective, that should be more than sufficient; but the production of those suits has been ramped up so that more and more are coming on line.

With respect to the defective garments, I understand that those have been taken out of the inventories and there have been orders to do so. None of those suits are being used in this current deployment.

So that's the——

Mr. STRICKLAND. Could I just interrupt there, just for a moment, for a point of clarification, because I'm not sure the information that I have is accurate, and I would be happy for you to tell me that it is not.

But I've been led to believe that there may have been up to a million suits that were questionable, that maybe three-quarters of those have, in fact, been identified and perhaps destroyed or in some way appropriately disposed of, but that there may be a significant number of those suits that are unaccounted for—they could be in an inventory, they could have already been destroyed, but we just simply do not know.

Is that a fair——

Dr. WINKENWERDER. That number is not one that I am familiar with, but what I could do is just take your question and get the information back to you——

Mr. STRICKLAND. Thank you, sir.

Dr. WINKENWERDER.—and provide you the most accurate information.

Mr. SIMMONS. As a point of order, was that a billion or a million suits, Mr. Strickland?

Mr. STRICKLAND. A million.

Mr. SIMMONS. A million. I heard you say a billion. I know that when we come to Washington, we change the "m" to a "b."

Mr. STRICKLAND. I meant to say a million.

Mr. SIMMONS. I thank you. So it was a million suits that might be defective.

Ladies and gentlemen of the panel, I thank you for your testimony, and we are now ready for Panel 2.

Panel 2 is made up of four gentlemen.

We have Peter S. Gaytan, Principal Deputy Director of the Veterans Affairs and Rehabilitation Commission of the American Legion.

We have Mr. Adrian Atizado, Associate National Legislative Director for the DAV.

We have Mr. Carl Blake, Associate Legislative Director, PVA.

And we have Mr. Richard Weidman, Director of Governmental Relations of the VVA.

We had initially intended to have five participants. Is Mr. Jones in the room, or is he not in the room?

He's way in the back.

Mr. JONES. I'm submitting written testimony.

Mr. SIMMONS. Submitting written testimony. God bless you. Thank you very much.

[Testimony not received at the time of printing.]

Mr. SIMMONS. Gentlemen, we will proceed as we have before. We will ask you for your statements. When the four statements are over, members of the committee will have questions and comments.

Please proceed.

STATEMENTS OF PETER S. GAYTAN, PRINCIPAL DEPUTY DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; ADRIAN M. ATIZADO, ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; CARL BLAKE, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; AND RICHARD WEIDMAN, DIRECTOR, GOVERNMENT RELATIONS, VIETNAM VETERANS OF AMERICA

STATEMENT OF PETER S. GAYTAN

Mr. GAYTAN. Let me begin by thanking you for allowing the VSOs to testify, not last, but on the second panel. Appreciate that courtesy.

Mr. SIMMONS. Right in the middle of the thick of things.

Mr. GAYTAN. Yes, sir.

Mr. SIMMONS. That's the way it's supposed to be.

Mr. GAYTAN. Yes, sir. Thank you very much.

I would also like to thank you for the opportunity to present the American Legion's views on the implementation of the Department of Veterans Affairs Emergency Preparedness Act of 2002 and VA/DOD efforts to coordinate force protection for those servicemembers who may be exposed to chemical, biological, or radiological weapons.

With our armed forces currently fighting a war in Iraq and the possibility of exposure to chemical weapons a major threat, not only to those troops who are deployed, but also to civilians within our own borders, these topics are of vital importance and we commend the subcommittee for holding this hearing.

Since September 11, there's been renewed interest in the nation's ability to adequately respond to a national emergency. Within that scope, the importance of VA's fourth mission as principal medical care backup for military health care has been reemphasized.

According to Title 38, the role of VA in a national emergency is to "furnish hospital care, nursing home care, and medical services to members of the Armed Forces on active duty." It is the responsibility of Congress to ensure VA is provided the funding and resources necessary to accomplish this mission.

In November of last year, President Bush signed into law the Department of Veterans' Affairs Emergency Preparedness Act, which

included the establishment of four medical emergency preparedness centers, staffed by VA employees and located at VA hospitals.

These centers would carry out research and develop methods of detection, diagnosis, vaccination, protection, and treatment for biological, chemical, or radiological attacks. Additionally, these centers would provide education, training, and advice to health care professionals, including those outside of VHA. They would also provide contingent rapid response laboratory assistance and other assistance to local health care authorities in the event of a national emergency. It further authorized $100 million for the establishment of these centers over the next 5 years.

The American Legion fully supported these recommendations, and we're here to tell you today that we still support those recommendations.

However, the fiscal year 2003 omnibus appropriations bill contained no provisions for establishing medical emergency preparedness centers or for funding a new office within VA for operations, security, and preparedness. The American Legion is outraged that the appropriators did not provide funding for the emergency preparedness centers at a time when we need them most.

VA cannot be expected to fulfill mandates without dedicated funding. The medical care accounts are already perpetually stretched to fulfill VA's primary mission of providing health care and services to veterans and their families. The American Legion will continue to support the funding needed to implement the provisions of Public Law 107–287.

In regards to force protection, the American Legion is greatly concerned with the safety and wellbeing of our troops who are deployed overseas currently. The need for effective coordination between VA and DOD is paramount.

Twelve years have passed since the first Gulf War, and many of the hazardous health conditions, apart from combat, are still major concerns of the current operations.

Advancing coalition forces are encountering burning oil wells and toxic smoke, increasing the potential for respiratory illnesses. Naturally occurring viruses, such as anthrax and malaria, are still ever present in that region. The continued use of depleted uranium munitions and the unresolved possibility of exposure contributing to further health complications are real threats to our servicemembers.

We must be vigilant in our efforts to ensure that the mistakes made in 1991 are not repeated today. I think that's been emphasized already this morning, and the American Legion supports and commends those members who brought that up today.

As our troops move closer to the capital city of Baghdad, the possibility of Iraq releasing chemical and biological weapons out of desperation increases dramatically. The American Legion is concerned about the ability of American military forces to operate and survive in a NBC environment.

During the 1991 war, the thousands of chemical detection alarms were later reported as "false alarms." The ability to properly detect the presence of NBC agents in the area of operation remains a grave concern.

Also this morning brought up, Member Strickland brought up, Congressman Strickland brought up the issue of the chem suits and their effectiveness. I included that in our written report, and we are gravely concerned about the effectiveness of these suits, especially the 250,000 that DOD believes have been either destroyed or taken out of the line of use by our troops.

We are very concerned with that, and we are continuing to try to resolve that issue and find out exactly where those 250,000 suits have been contained or where they've gone, to make sure that our troops are not using those.

But of greater concern is VA/DOD's ability to work together to ensure that our troops are receiving pre-deployment physicals, post-deployment physicals, to accurately assess exposure and effect of health during their deployment. It's of vital importance that VA and DOD do this.

Currently, DOD is required by Public Law 105–85 to improve medical tracking of health care of those deployed troops.

The American Legion understands that DOD is currently using Forms 2795 and 2796, DD Forms, as questionnaires for returning servicemembers who have been deployed. Instead of accurately providing full physicals for these returning troops, these troops are filling out questionnaires, and the American Legion is concerned about the effectiveness, or lack thereof, of omitting an actual physical and just requiring these servicemembers to fill out questionnaires with basic health care questions.

We would like to see DOD fulfill that mandate and provide those full physicals for those returning servicemembers, to ensure that if they were exposed to chemical, radiological, or biological weapons, that we will be able to assess their health care needs and provide those in a timely manner through the VA.

So the American Legion is concerned about both of those issues today.

I ask that our full testimony be submitted for the record, and I'm available to answer any questions you may have.

[The prepared statement of Mr. Gaytan appears on p. 116.]

Mr. SIMMONS. Without objection, all full testimonies will be submitted for the record, and any other documentation you wish to submit.

STATEMENT OF ADRIAN M. ATIZADO

Mr. ATIZADO. Good morning, Mr. Chairman, members of subcommittee. I'm pleased to express DAV's views before the subcommittee on the status of Public Law 107–287, the Department of Veterans Affairs Emergency Preparedness Act of 2002, as well as post-deployment health care for our nation's veterans.

Today's hearing is especially timely, considering the situation our nation finds itself in, in the world today. We are facing an uncertain future as to the extent of military involvement and likely additional attacks in the United States in response to formal military actions.

We believe VA is an essential asset, having a multitude of resources and expertise that could be utilized in federal emergency efforts. Therefore, we do look to VA to address some of these concerns.

The Veterans' Health Administration, or VHA, is the nation's largest direct provider of health care services, with over 1,300 medical facilities. VHA annually trains approximately 85,000 health care professionals and has a number of affiliations with medical schools across the country.

Should domestic terrorist attacks occur, the VA's role is to augment the efforts of state and local authorities. It also has a supporting role as part of the Federal Response Plan and National Disaster Medical System.

VHA also supports the Public Health Service and Health and Human Services' Office of Emergency Preparedness to ensure that adequate stockpiles of antidotes and other necessary pharmaceuticals are maintained nationwide.

VA also plays a critical role in post-deployment health care for veterans.

Now, due to past conflicts, the VA has developed a core of specialized medical programs and treatments, which is known nationwide—worldwide, as a matter of fact. It has expertise in areas such as radiation exposure, exposure to toxic chemical, biological, and environmental agents, and has, as Dr. Roswell mentioned earlier, recently developed two Centers for the Study of War-Related Illnesses.

DAV was supportive of the passage of the Department of Veterans Affairs Emergency Preparedness Act of 2002. However, concerns noted in our previous testimonies remain.

As this subcommittee is well aware, VA is currently struggling to carry out its first and primary mission. This is to provide timely, quality health care to our nation's veterans.

Now, we believe VA must be provided with sufficient funding to correct current deficiencies, also to enable it to respond quickly to new threats and carry out all its missions.

As part of the independent budget, we recommend Congress appropriate $20 million for fiscal year 2004 to fund the four emergency preparedness centers.

We also recommend Congress include a separate line item in the medical care account. This is to fund the development of education and training programs on medical response which is to be disseminated to the health care providers within and outside VA.

Lessons learned in post-deployment health care from previous conflicts yielded some accomplishments in areas which were mentioned earlier today: information management, recordkeeping, quality of pre and post-deployment health assessments, medical surveillance during deployment, troop location, and environmental surveillance assessments. However, DAV believes more can be achieved in these areas.

For example, we are greatly concerned about what was said during Tuesday's hearing before the House Subcommittee on National Security, Emerging Threats, and International Relations.

Now, the second panel before that subcommittee clearly voiced their concern over the pre-deployment health assessment. Specifically, they questioned the quality and comprehensiveness of both the blood samples and the questionnaires utilized, and specifically as it relates to its intended purpose.

Although the final responsibility to ensure the viability of the data collected rests with the Department of Defense, VA bears the responsibility of utilizing all the information DOD has collected, and we look to this subcommittee, as well as the House Committee on Veterans' Affairs, to provide oversight over these matters.

So as you see, Mr. Chairman, we are confident that VHA and its dedicated staff will do its utmost to meet its responsibilities to care for those who are injured. However, we must have sufficient—I'm sorry—VA must have sufficient resources to carry out all of its missions. We strongly urge this subcommittee to ensure adequate funding be allocated to VA for these mandates.

Mr. Chairman, that concludes my statement. I would be happy to answer any questions you may have.

[The prepared statement of Mr. Atizado appears on p. 122.]

Mr. SIMMONS. I thank the gentleman.

If the panel would suspend for one moment, I see that Dr. Roswell is about to leave.

Before he escapes, I was wondering, for the record, Dr. Roswell, it occurs to me that the VA must have established some internal memoranda or RFP involving the establishment of the four centers that have been the topic of this discussion.

Would you be able to provide those to the committee for our record?

Dr. ROSWELL. Yes, Mr. Chairman, I'd be happy to submit for the record the planning efforts we've taken in the event we receive appropriated funds to begin to implement the four emergency preparedness centers.

(The information follows:)

NOTE: SUBJECT TO RECEIPT OF APPROPRIATIONS

DRAFT

MEDICAL EMERGENCY PREPAREDNESS CENTERS (MEPC)
Request for Applications

INTRODUCTION: The Under Secretary for Health announces the opportunity for VA facilities to submit applications to compete for core funding to establish VA Medical Emergency Preparedness Centers (VA MEPCs). Each established center will have a focus and all funded centers will work in collaboration to fulfill the intent of PL 107-287. The Centers for which applications are sought by this program announcement are to be focused in **one** of the following three areas:

1. VA Medical Emergency Preparedness Center for Research Resources
2. VA Medical Emergency Preparedness Center for Education and Training
3. VA Medical Emergency Preparedness Center for Operations, Management, and Consultation

This opportunity is open to all medical facilities in the VA health care system. Applicant VA medical facilities must select **one** of the Center foci for application.

BACKGROUND AND OVERALL GOALS: Establishment of VA Medical Emergency Preparedness Centers was authorized by PL 107-287, "The Department of Veterans Affairs Emergency Preparedness Act of 2002". Section 2 of this Act specifically authorizes VA to establish these Centers to:

1.) Carry out research on detection, diagnosis, prevention and treatment of medical consequences arising from the use of chemical, biological, radiological or other threats to public health and safety.
2.) Provide education, training and advice to VA health care professionals on these topics and also, when needed, to non-VA health care professionals generally through the National Disaster Medical System [NDMS]), and
3.) Provide laboratory, epidemiological, medical or other consultation and assistance required in the event of such a disaster or emergency.

The principal goal of these Centers is to become the recognized leader and coordinator of VA medical emergency preparedness activities in interrelated but distinct areas: research, education and training, operations management, and consultation and assistance during emergencies resulting from the use of chemical, biological, radiological or other threats. It is expected that these Centers will work in close collaboration with other VA entities (organizations, offices, and individuals) to ensure that VA: 1) conducts relevant and meaningful research in medical emergency preparedness and put results of that research to use; 2) successfully educates and trains VA personnel in medical emergency preparedness using the most effective materials and methods; 3) develops and implements the most appropriate organizational management strategies that prepare VA to successfully respond in the event of an emergency or disaster to best care for veterans and to assist where VA endowments are needed. Thus, individual applications are sought for each of the following distinct types of VA Medical Emergency Preparedness Centers:

1.) **VA Medical Emergency Preparedness Center for Research Resources.** The Center funded in this area will lead and enhance VA's research efforts in areas of medical emergency preparedness by identification of research needs, offering of grants to VA facilities to establish appropriate research infrastructure that lead to successful research programs in detection and diagnosis, prevention of injury, and treatment of health-related consequences of chemical, biological or radiological threats to public health and safety. The products of the activities of this Center will be the funding, implementation, and accomplishment of VA research studies in these areas by VA and other governmental or research-sponsoring organizations.

2.) **VA Medical Emergency Preparedness Center for Education and Training.** The Center funded in this area will lead VA's efforts to identify, develop and disseminate materials, programs and curricula to educate and train VA health care professionals to both prepare for and respond to emergencies or threats to public health and safety. This Center will also create and sponsor a Fellowship program in Medical Emergency Preparedness and establish a Certification program for Medical Emergency Preparedness Program Coordination.

3.) **Medical Emergency Preparedness Center for Operations, Management, and Consultation.** The Center funded in this area will lead VA's efforts in the study and implementation of operational and management aspects of health care facility organization, administration, operation and managerial preparations and responses needed for emergencies or threats to public health and safety. The products of the activities of this Center will be proven "best practice" operations and management strategies and systems for medical emergency preparedness. These operations and management practices will be made available throughout the VA system. This Center will also work with VA leadership and VA Area Emergency Managers to coordinate delivery of VA expertise and resources to emergencies or situations that are threats to public health and safety.

Once funded, these Centers will work as one organization, supervised by the Under Secretary for Health, in consultation with VA leaders with responsibility for operations, preparedness, security, and law enforcement functions, to fulfill the goals of PL 107-287. It is strongly suggested that potential applicants review Section 2 of PL 107-287, The Department of Veterans Affairs Emergency Preparedness Act of 2002.

Specifically, each Center will be expected to:

- Build on available expertise in the selected area to accomplish VA missions and become a nationally recognized leader in that area;
- Develop and maintain substantive, mutually beneficial, collaborative partnerships with other funded Centers and with appropriate VA offices;
- As appropriate to its mission, develop and maintain substantive, mutually beneficial, collaborative partnerships with schools of medicine, public health, or other health professional education program appropriate to the goals/projects proposed;

Disseminate Center results, programs, plans, products and recommendations to all appropriate VA end-users including national VA leadership, VISN and facility staff and all VA personnel.

VA MEDICAL EMERGENCY PREPAREDNESS CENTERS OPERATION

The VA Medical Emergency Preparedness Centers will operate together as a unified national resource supervised by the Under Secretary for Health, in consultation with VA leaders with responsibility for operations, preparedness, security, and law enforcement functions. Each funded Center will be required to collaborate and coordinate with other funded Centers as well as with other VA organizations, offices and personnel. An open and competitive process will establish these Centers. Center performance standards and deliverables will be defined and continued funding will be contingent on funded Centers' progress and success in meeting these standards.

REQUEST FOR APPLICATIONS INSTRUCTIONS

Written proposals for establishing a VA MEPC will represent the VA facility's best work plan for achieving the VA MEPC program goals and objectives. Reviewers will assess the information provided for scientific merit, responsiveness to this program announcement, and operational feasibility. Proposals that accurately reflect the applicant VA facility's existing or potential activities, resources, and programmatic strengths in VA Medical Emergency Preparedness and for this program will be viewed more favorably than those that report primarily the programs and resources of the affiliated university or medical/public health school.

All medical emergency preparedness activities and projects conducted pursuant to this solicitation must be performed at the host VA medical center. Under some circumstances, certain activities related to the function and projects of funded VA MEPCs may be conducted at a collaborating institution subsequent to the approval of the Under Secretary for Health. Each VA MEPC will be funded on a five-year cycle.

Application instructions and the format follow the following outline:

0.0 General Instructions

1.0 Executive Summary

2.0 Administrative Structure

3.0 VA Medical Emergency Preparedness Center Focus Areas

- VA Medical Emergency Preparedness Center for Research Resources
- VA Medical Emergency Preparedness Center for Education and Training
- VA Medical Emergency Preparedness Center for Operations, Management, and Consultation

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4.0 MEPC Program Evaluation Plan

5.0 Implementation Plan

6.0 Budget Plan/Template

0.0 GENERAL INSTRUCTIONS

- Receipt deadline. **A Letter of Intent indicating intention to submit must be faxed to VACO Office of Public Health and Environmental Hazards, Public Health Strategic Health Care Group (13B), 202 273-6243 or 9078 by XXX, ATTN: Dr. Lawrence Deyton.**

- Complete final proposals must be received in VA Headquarters by **XXX**. Address proposals to:

  Public Health Strategic Health Care Group (13B)
  Office of Public Health and Environmental Hazards
  Department of Veterans Affairs
  Attn: Dr. Lawrence Deyton, Room 852
  810 Vermont Avenue, N.W.
  Washington, DC 20420
  (202) 273-8567

- Late Proposals and Material: Proposals or additional materials for submitted proposals that arrive after the application deadline will not be included in the review process.
- Number of copies. One (1) unbound original plus seven (7) complete copies of the proposal are required.
- Number of pages. The total length of the proposal (not including appendices, pilot research projects, and biographic sketches) must not exceed 30 pages. Excessively lengthy proposals will be viewed less favorably than those that present essential information concisely and with organizational clarity and logical development.
- Format. Each page must be typed, single-spaced, on one side only. Font should be 12 point.
- Pagination. Pages of text are to be numbered sequentially in the bottom right corner.
- Organization. The proposal must conform to the sections/subsections specified in these Instructions. Each of the primary sections and each appendix must start on a new page.
- Identification. Each page should have the name of the submitting VA Medical Center (VAMC) indicated in the upper left corner.
- Letters of Support. Letters of support are expected from relevant individuals who have active and named involvement in the VA MEPC application. These should be included in the appropriate appendix. NOTE: General letters of support from interested parties (advocates, elected officials, etc.) will not be included in the review process.

1.0 EXECUTIVE SUMMARY: This summary should not exceed 2 pages and give an overview of the application.

1.1 IDENTIFYING INFORMATION. Provide the following essential information:

- Name and address of the VAMC submitting the proposal. If more than one facility is included in the proposal, provide the name and address of all facilities participating (VA *and* non-VA facilities and institutions) in the proposed VA MEPC.
- Identify the FOCUS AREA SELECTED for this VA MEPC application.
- Name, telephone number, and e-mail address of:
  - One proposed VA MEPC Director
  - VAMC Director (of the lead VA MEPC facility)

2.0 VA MEPC ADMINISTRATIVE STRUCTURE. This section should concisely describe the administrative structure that will support the goals and objectives of the VA MEPC program, (i.e., within the VA facility, with affiliated professional schools, and with other participating organizations). If the proposal is a multi-facility VA MEPC, the organizational and administrative relationship between the facilities must be clearly described.

2.1 VA MEPC ORGANIZATIONAL STRUCTURE. Provide a functional organizational chart of core staff positions (and names, if known) to be supported by VA MEPC funds. If the proposal is a multi-facility VA MEPC, indicate how the VA MEPC FTEEs will be allocated, coordinated and tracked. Provide a biographic sketch (VA Forms 10-1313-5 and 10-1313-6) of the proposed VA MEPC Director. This position must be held by a Title 38 VA employee who holds a $5/8^{th}$ to $8/8^{th}$ FTEE. Other principal VA MEPC leadership should range from $5/8^{th}$ to $8/8^{th}$ VA FTEE. *Under exceptional circumstances,* principal VA MEPC leadership who are less than $5/8^{th}$ VA employees may be allowed by the Chief Consultant, Public Health Strategic Health Care Group (13B). This request must be submitted as part of the initial proposal for peer review.

2.2 VA MEPC ADVISORY COMMITTEE.

- Provide essential information concerning plans and time frames for establishing this committee:
  - purpose/objectives/responsibilities.
  - membership (size, composition, selection/rotation procedures). If the proposal is for a multi-facility VA MEPC, indicate representation from each VA and each affiliate.
  - reports/records (type and distribution of reports/information, certification of decisions/recommendations).
- Describe functional and structural relationships to other VA and non-VA organizational entities.

2.3 PARTICIPATING VA FACILITIES.

- Describe the structural and functional relationships between the proposed VA MEPC, the host VAMC and other participating VA facilities. Describe the programs, services and facility resources that will be interfaced with or "contributed" to the VA MEPC. If the proposal is for a multi-facility VA MEPC, describe the relationships and resources for each

facility involved. Provide names and telephone numbers of all participating individuals.

2.4 PARTICIPATING INSTITUTIONS

- Describe any participating institutions (medical, public health or other health professional schools) or facilities. Provide names and telephone numbers of participating representatives. Describe in full any participating academic programs in medical emergency preparedness or activities related to this application.
- Specify the functions/resources to be provided by each collaborating institution and explain how it would enhance a VA MEPC Program.
- Describe the collaborating institutions' structural relationships to the VA Facility and VA MEPC.
- Append a copy(ies) of any current or proposed Memoranda of Agreement.

2.5 VA MEPC AS A GEOGRAPHIC RESOURCE

- Describe the VA MEPC resources, in terms of research, education and event consultation that would be useful to the VA facilities or geographic emergency responses in your network.

2.6 VA MEPC AS SYSTEM-WIDE RESOURCE

- Describe specifically the VA MEPC resources, in terms of research, education and event consultation that would be useful to the VA system as a whole. Include how your VA MEPC would either complement the resources or add a new dimension for advancing VA or national medical emergency preparedness.
- Describe how your VA MEPC will function as a component of a consortium with the other funded VA MEPCs.

3.0 MEDICAL EMERGENCY PREPAREDNESS CENTER FOCUS AREAS: Applicant institutions must apply in one of the following areas.

Please format applications according to the recommendations specific to the focus area chosen.

VA Medical Emergency Preparedness Center for Research Resources. The Center funded will be charged with identification of research needs in detection and diagnosis, prevention of injury, and treatment of health-related consequences of chemical, biological or radiological threats to public health and safety that are needed to serve veterans and VA's local and national communities. The Center will function in four interrelated areas to:

1.) Perform research in an area related to the mission of the VA MEPC program,
2.) Link VA researchers in all areas of relevant research with potential co-investigators and funders,
3.) Award small grants to assist in the establishment of research infrastructure, and
4.) Provide mentoring and advice to potential investigators.

All applications for the VA Medical Emergency Preparedness Center for Research Resources should include the following elements:

a. Leadership or co-leadership by VA scientists who have made significant contributions in medical research. Those with a track record in the development of successful and innovative approaches to the detection, diagnosis, prevention or treatment of injuries, diseases and illnesses arising from the use of chemical, biological, radiological, incendiary or other explosive weapons or devices posing threats to the public health and safety will be viewed especially favorably.
b. Conduct of one or more focused research projects that emphasize clinical application in detection, diagnosis, prevention or treatment of injuries, diseases, or illnesses arising from these types of events.
c. Coordination and catalyzing linkages between potential collaborators and funders with qualified potential VA researchers in all areas solicited by this program (detection, diagnosis, prevention or treatment of injuries, diseases and illnesses arising from the use of chemical, biological, radiological, incendiary or other explosive weapons or devices posing threats to the public health and safety). These efforts should lead to funding of research projects in all areas specified by this program, most of which would be performed by VA researchers other than the Center staff.
d. Promotion and promulgation of needed research by mentoring other researchers through the provision of small grants to develop research infrastructure or by provision of advise/assistance.

NOTE 1: A successful application might propose three separate and interrelated activities such as a) research to be conducted in one area specified by this program where the applicant possesses unique expertise and experience, b) establishment of a research clearinghouse or coordinating center that links qualified VA researchers with potential collaborators and/or funders and c) establishment of a program to make infrastructure grant awards and a research mentoring program to build VA research capacity in these areas.

NOTE 2: The VA Medical Emergency Preparedness Center for Research Resources will work closely with the VHA Office of Research and Development in order to facilitate development of research proposals and submission of projects to VA Merit Review.

VA Medical Emergency Preparedness Center for Education and Training. The Center funded in this area will have the principal responsibility to assure VA health professionals receive appropriate education and training in order to be optimally prepared in the areas of detection and diagnosis, prevention of injury, and treatment of health-related consequences of chemical, biological or radiological threats to public health and safety. At a minimum, Center functions should be focused on several major activities:

- Optimal use of existing materials across VA and NDMS facilities (i.e., identify, disseminate and expand upon excellent existing materials).
- Identification of education/training gaps, development and dissemination of new education/training materials across VA and NDMS facilities.
- Establishment of Fellowship Programs in VA Medical Emergency Preparedness in the areas of research, education, risk communications and operations management.
- Establishment of Certification Program in VA Medical Emergency Preparedness Program Coordination.

The Director of the VA Medical Emergency Preparedness Education and Training Center will be expected to work seamlessly with the Directors of all other funded VA Medical Emergency Preparedness Centers to identify education and training opportunities, needs and changes based on the work products of those other Centers.

Centers selected for funding under this RFA are to be established at VAMCs and to have developed (or are anticipated to develop) the following attributes:

1.) An arrangement with a medical school and school of public health where VA physicians and other VA health care practitioners receive education and training to detect, diagnose, prevent and treat injuries, diseases, and illnesses induced by exposures to chemical and biological substances, radiation, and incendiary or other explosive weapons or devices.
2.) An arrangement with graduate school specializing in epidemiology where VA physicians and VA health practitioners receive training in the epidemiology of contagious and infectious diseases and chemical and radiation poisoning in an exposed population.
3.) An arrangement under which nursing, social work, counseling or allied health personnel and students receive training and education in recognizing and caring for conditions associated with exposures to toxins through the participating VA facility.
4.) Establishment and maintenance of an official linkage with the VA Employee Education Service.
5.) Establishment and maintenance of an official linkage with the VA Office of Academic Affiliations (to facilitate #1,2, and 3, above).

Medical Emergency Preparedness Center for Operations, Management and Consultation. The Center funded in this area will have the principal responsibility to identify, catalyze, and lead VA efforts and activities to study how the VA health care system should be operated and managed to optimally provide for detection and diagnosis, prevention of injury, and treatment of health-related consequences of chemical, biological or radiological threats to public health and safety. This Center will have lead responsibility to recommend operations and management changes to VA health care organizations that will lead to improvement in these areas. This Center also will function as a VA resource to assist with responses in the event of chemical, biological,

radiological, or other event and will be available to offer advice, consultation, or assistance to VA, local, state, regional, or national response systems. Thus, this Center will be should be focused on several major activities:

1. Catalyzing VA operations and management research projects
2. Communication/coordination about these topics with other VA and non-VA organizations of health care and medical emergency preparedness
3. Preparation of an annual compendium on identification and implementation of operations and management improvements applicable to the VA health care system
4. Development of a coordination plan with other VA offices (The Office of Security and Preparedness, Public Health and Environmental Hazards/Emergency Management Strategic Health Care Group, Patient Care Services/Pharmacy Benefits Strategic Health Care Group) and National Disaster Medical System (NDMS).

4.0 VA MEPC PROGRAM EVALUATION PLAN

- Describe the components of the local VA MEPC Program Evaluation Plan.
- Describe the processes and procedures for reviewing and updating the adequacy and effectiveness of the evaluation plan.
- Describe resources for carrying out evaluation activities, i.e., computers and peripherals (particularly capabilities for an on-line VA MEPC Management Information System and Intra/Internet access) optical scanners, other equipment, supplies, or expertise.

5.0 IMPLEMENTATION PLAN

- The first year of funding for a new VA MEPC is intended to support the VA MEPC infrastructure and identified VA MEPC core staff positions, at least one-half of whom should be on board in the VA MEPC at the beginning of operation, with full capacity achieved by the end of the first year. Explain what "half" and "fully" operational would mean for your VA MEPC, and how it would be achieved.
- Major areas of infrastructure concern that require elaboration in the Implementation Plan include staff recruitment, development of administrative structures, implementation of affiliation agreements, acquisition of materiel resources (space, equipment, etc.), and any necessary remodeling and renovation of space for offices, laboratories, etc.
- It is anticipated that the host VAMC and/or VISN will provide the basic infrastructure to support this initiative. This infrastructure includes such items as co-located clinic/office space for VA MEPC staff, IT installation and ongoing support services, administrative, human resources, contract and Interagency Agreement/IPA support, equipment purchase and maintenance and budget and accounting support.
- The host VAMC should describe how its existing structure(s)/resources satisfies these requirements, and/or what resources the VISN will commit to satisfying these infrastructure needs.

6.0 BUDGET PLAN

- Three types of information are required: FTEE, staff salary dollar estimates, and equipment needs. Provide this information using the enclosed spreadsheet template/format following this section. The format provided may be modified as needed. If legal size paper is needed, it should be reduced to regular letter size paper before inclusion in the proposal package.
- Two time periods are needed: (1) the first (developmental) year, and (2) the second (fully operational) year. **Note: It is suggested that recruitment of all primary core staff take place as early in the developmental year as possible.**

General Notes: Any appendices or note (e.g., curriculum vitae) must be titled, numbered and keyed to the appropriate proposal section. Appendices should be clear, concise, and relevant (not used to "pad" the proposal with quantities of information). Lengthy resumes of individuals are discouraged, and should be abbreviated to emphasize only experiences, publications, and achievements relevant to medical emergency preparedness and the activities of this proposal.

DRAFT

Timeline for Establishment of
4 VA Medical Emergency Preparedness Centers (MEPCs)

Establish VACO Steering Panel:	Immediately upon Appropriation date
First Meeting of VACO Steering Panel:	Appropriation + 3 days
Draft 1 RFP to VACO Steering Panel for review:	Appropriation + 10 days
Comments returned to RFP coordinator:	Appropriation + 15 days
Draft 2 RFP circulated to VACO Steering Panel:	Appropriation + 20 days
Second Meeting of VACO Steering Panel: Agenda: finishing touches on final RFP; discussion of scientific review criteria establish procedure for handling of questions on RFP	Appropriation + 25 days
Final Draft RFP circulated to others in VACO:	Appropriation + 30 days
Comments due to RFP Coordinator:	Appropriation + 35 days
RFP to 10 for Final Review and Signature:	Appropriation + 42 days
RFP Issued: Accompanied by USH announcement	Appropriation + 45 days
Letter of Intent Due:	Appropriation + 60 days
Invitations to Potential Members of Peer Review Panel:	Appropriation + 70 days
Deadline for Receipt of Proposals: 8 week application period.	Appropriation + 105 days
Peer Review Panel finalized (by 12):	Appropriation + 110 days
Assignments and review plan to Review Panel (12):	Appropriation + 112 days
Two – Day Meeting of Peer Review Panel: days	Appropriation + 160-162
Funding Recommendation Meeting:	Appropriation + 170 days
Funding Recommendation Submitted to Secretary by USH:	Appropriation + 180 days
Selection of 4 MEPCs by Secretary: Awardees notified.	Appropriation + 190 days
First Funds to 4 MEPCs:	Appropriation + 205 days

Dr. ROSWELL. I also apologize. I have to catch a flight, or I would otherwise certainly stay for the remainder of the hearing.

Mr. SIMMONS. Well, I appreciate that, and yes, those documents would be useful to us as we move forward, since we, of course, are going to try to change that situation, so it would be very helpful.

Mr. RODRIGUEZ. Mr. Chairman, I would also just like to follow up, because we went through—my understanding is we made an assessment for 2003 that basically says 9/11, some of the costs.

I'd like to get some additional, if we can get it, you know, because we looked at it in terms of training that's required throughout the system in preparing, you know, the—just the overtime.

I know every time we go to Code Orange, you guys have to also, you know, beef up, you know, the prescriptions and items that might be needed in case of an attack. We figured that just that alone was about $50 million for 2003, and possibly another $66 million for 2004.

I'd like to get a more accurate, you know, figure from you on that if it's okay with the chairman, because as we look, you know, at what expenses that have already occurred, if possible.

Mr. SIMMONS. Absolutely. We will go forward with that request for the record.

Thank you, Dr. Roswell. Don't miss your plane.

Dr. ROSWELL. Okay. Thank you very much. I will provide that. We do have that information.

(The information follows:)

Enhancement of Emergency Preparedness (Homeland Security) -
2004 President's Submission

	2002	2003	2004	Increase/ Decrease
Obligations ($000).....	$46,000	$122,200	$131,000	$8,800

Breakout of FY 2003 Estimate

Description	Millions
Pharmaceutical caches	$26.0
Providing personal protection equipment, decontaminant equipment, and the appropriate training of our health care workers and Environmental Safety Specialists/Review Staff (those most likely to be placed in circumstances involving victims of a biological or chemical weapon attack). ...	$15.2
To provide 24 hours - 7 days a week (24X7) National Help Desk coverage. The National Help Desk currently only operates during normal business hours. After hour coverage is normally performed by pager support. With the use of pagers a great deal of time can be spent waiting for a response	$1.0
Overtime for Security Service Personnel.....	$5.1
VHA's reimbursement to Department for Cyber Security.....	$74.9
Total.....	$122.2

Breakout of FY 2004 Estimate

Description	Millions
Pharmacy caches program (inventory & replacement).....	$7.20
Establish casualty treatment database for WMD victims.....	$6.00
Cyber Security & IT Testing (VHA portion).....	$24.95
Upgrade VA Primary COOP (VHA portion)	$10.75
Purchase of PPE suite.....	$3.40
Decon. Facilities (200*$50,000).....	$10.00
Environmental Specialists	$11.30
Fortify police force (overtime and hiring).....	$30.10
Training.....	$3.00
Radio Frequency Replacement Wide-band to Narrow.....	$24.30
Total.....	$131.00

Mr. SIMMONS. And now we'll proceed with Mr. Blake. Welcome.

STATEMENT OF CARL BLAKE

Mr. BLAKE. Chairman Simmons, Ranking Member Rodriguez, members of the subcommittee, PVA would like to thank you for the opportunity to testify today concerning the status of the implementation of Public Law 107–287, the Department of Veterans' Affairs Emergency Preparedness Act of 2002.

Mr. Chairman, PVA would also like to thank you for your efforts on behalf of veterans, to ensure that the fiscal year 2004 budget resolution which was passed last week will provide adequate funding levels to allow the VA to provide proper health care to our veterans.

The cuts proposed in the resolution would have been devastating to the VA and to veterans as a whole, and we appreciate your efforts and Chairman Smith's efforts and the efforts of Members of Congress. It really saved the day.

Mr. SIMMONS. We airborne officers have to stick together.

Mr. BLAKE. We will, sir.

Public Law 107–287 authorized the Secretary of Veterans Affairs to establish four emergency preparedness centers within the VA for research and development to education and train health care professionals, and to provide support to federal, state, and local agencies.

Section 3 of the law required the VA to develop and disseminate a series of model education and training programs on the medical responses to the consequences of terrorist activities.

Section 4 authorized the VA to provide hospital and medical services to individuals affected by natural disasters or national emergencies, to include all veterans, whether enrolled in the system or not, and active duty military personnel.

Finally, Section 5 established the Secretary to establish an Assistant Secretary for Operations, Preparedness, Security, and Law Enforcement.

Public Law 97–174, the Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act, currently part of 38 USC 811A, established the VA as the principal medical care backup for military health care "during and immediately following a period of war, or a period of national emergency declared by the President or Congress that involves the use of armed forces in armed conflict."

This constitutes explicit statutory authority for the fourth mission of the VA. With soldiers currently in the field in combat, this mission is very much a priority at this time.

An important part of the VA's critical fourth mission is to also assist states and localities.

The GAO, in a January 2001 report entitled, "Major Management Challenges and Program Risks," characterized the VA's role as the "primary backup to other federal agencies during national emergencies."

The GAO further stated, the "VA's role as part of the Federal Government's response for disasters has grown with the reduction of medical capacity in the Public Health Service and military medical facilities."

The VA is the only health care system that is capable of providing a comprehensive and national response to the threats we face from terrorist activities and national disasters and emergencies. This important and vital role was clarified explicitly in Public Law 107–287 under the provisions of section 4. These provisions include war-wounded soldiers who will return from the front lines of Iraq and Afghanistan.

A particular concern of PVA is the fact that the recently enacted fiscal year 2003 omnibus appropriations act, Public Law 108–7, prohibited funding of all section of this law except Section 3 and 4. This effectively prevents the VA from creating the four emergency preparedness centers as well as establishing the new Assistant Secretary position. We have serious concerns with this practice of legislating through the appropriations measures.

Mr. Chairman, I would like to submit for the record a copy of an article published in *Washington Post* on Tuesday, March 25, entitled, "VA Posed to Help Care for Troops." This article clearly outlines the importance of the VA's fourth mission.

(The information follows:)

1 of 1 DOCUMENT

The Washington Post

March 25, 2003 Tuesday
Final Edition

SECTION: A SECTION; Pg. A07

LENGTH: 696 words

HEADLINE: VA Poised to Help Care for Troops;
Veterans Facilities Prepare to Take Military Hospital Overflow

BYLINE: Edward Walsh, Washington Post Staff Writer

BODY:

In the war with Iraq, it is the White House and the Pentagon that are holding center stage. But in the background, the Department of Veterans Affairs also has been preparing for armed conflict and its aftermath.

By the nature of its mission, the VA is not on the front lines. But the agency's sprawling health care system serves as the primary backup for the health care system run by the Defense Department and the military services. VA officials hope they will not be needed to help, but if the number of casualties returning from the Persian Gulf begins to put too much strain on military hospitals, VA facilities would be the first to take up the slack.

"You could see us make as many as 7,000 beds available," VA Deputy Secretary Leo Mackay said in an interview before the war began.

The VA is also the lead government agency in overseeing the National Disaster Medical System, a network of about 2,000 civilian hospitals across the country that have volunteered to help if a disaster overwhelmed the health care capacity of a local community. It could also be activated to care for war casualties if needed.

Kristi L. Koenig, director of the VA's emergency management strategic health care group, said the agency is doing more frequent monitoring of the civilian system so that it knows what resources are available in addition to VA hospitals.

"DOD doesn't give us a number and say be prepared to take so many casualties, " she said. "We tell them how many we can take."

Speaking in an interview before the war was launched with Iraq, Koenig said the military services and the VA take a regional approach in deciding where military personnel returning from a war zone should be treated, attempting to place them in hospitals close to where their units are based.

If the military hospitals in a region became overwhelmed, VA hospitals in the region could take the overflow. And if both military and VA facilities become swamped, the civilian hospitals in that region that are part of the National Disaster Medical System become the third line of defense, she said.

The Washington Post March 25, 2003 Tuesday

U.S. casualties in the Persian Gulf War in 1991 were light, and there was no need to call on the VA for medical help. But unlike in 1991, the VA and other agencies are now also preparing for the possibility that this war will be brought home in more ways than the return of the wounded from the front lines.

"One of the things that's different is we have an increased concern for retaliatory strikes and are preparing for other roles such as terrorist attacks in the U.S.," Koenig said. This has led to "intense training" for VA personnel in some new areas, she said, including decontamination methods, the use of personal protection equipment, and testing and safeguarding of communications systems.

The VA has also tried to learn from the experience of the Gulf War and its aftermath. Numerous veterans of that conflict were later afflicted with a variety of ailments that, collectively, became known as Gulf War Syndrome, the cause of which has never been determined.

In the last two years, the VA has established two centers, in Washington and East Orange, N.J., to conduct research on war-related illnesses. Mackay said this was a direct outgrowth of the Gulf War.

The VA and the Pentagon are also trying to do a better of job of developing information on the health of service personnel before and after a deployment to a combat area such as the Persian Gulf region.

Mackay said the Defense Department has been doing a pre-deployment health screening and questionnaire before troops ship out to the Gulf and will do the same when they return, sharing the information with the VA because that agency will inherit the long-term health care responsibility for the veterans.

"There is a real commitment to do it differently this time," he said.

One great unknown still is whether Iraq will unleash chemical or biological weapons on U.S. forces. VA officials would not discuss this aspect of their planning in any detail, but Mackay said they are in "constant communications" with the Pentagon "about what kind of casualties that may occur and that includes talk about chemical and biological injuries."

LOAD-DATE: March 25, 2003

Mr. BLAKE. Mr. Chairman, I'd like to thank you for the opportunity to testify today, and I'd be happy to answer any questions you might have.

[The prepared statement of Mr. Blake appears on p. 124.]

Mr. SIMMONS. Thank you. The fourth panelist is Mr. Weidman.

STATEMENT OF RICHARD WEIDMAN

Mr. WEIDMAN. Mr. Chairman, on behalf of Vietnam Veterans of America, I wish to thank you for this opportunity to be here today.

I was going to congratulate Dr. Roswell. He is doing leadership by example in staying to hear what other witnesses have to say at hearings. This is a trend that should be followed by all of our public officials. In fact, the rudeness—they should have learned in kindergarten that you don't walk out in the middle of a conversation, and hopefully, other witnesses will—I can assure you that I will be here for the third panel.

We have two important issues here today. One is dealing with domestic terrorism and bioterrorism and the lack of funding of the significant piece of legislation passed by the Congress last year.

The funding of $20 million, we can debate where that funding source should come from. Should it come from HHS? Should it come to the Department of Homeland Security? Is it conceptually wrong for it to come out of veterans health care medical operations?

Whatever the source, VVA strongly favors let's put all that aside and move forward. We need to get these four preparedness centers up and running. It is vital to the American people. It is not a vested interest.

We would note for the record, on a personal note, if we may, Mr. Chairman, and that is the recent edition of Roll Call, which has Chairman Smith's picture under the title, "Vested Interests."

We need to speak and educate our friends at Roll Call. Veterans are not a vested interest. They have put their lives on the line, and limbs, in defense of the Constitution of the United States, and damn sure are not a vested interest, number one.

Number two, we would note that, if you'll notice the appendix to our statement submitted for the record, sir, you will notice that had VA funding kept up, on a per capita basis, the number of people using the system, and inflation, as determined by the Center for Medicaid and Medicaid Services of the Social Security Administration, we would be discussing whether we needed $37 billion or $35 billion for fiscal year 2004.

This debate has become skewed. It's not that veterans are asking for too much money and it's not a veterans' problem. We believe, at Vietnam Veterans of America, that it's an American problem.

If you can't take care of the men and women who are defending the United States' interests all over the world, including here at home, in military service, which is a tough and dangerous occupation even in the best of times, then something is dramatically wrong with our priorities and we need to re-examine out national family values, we would suggest.

So anyway, what I would also like to note at this point, that in regard to the fourth mission, that we have an article here that was published in December, which we have shared with staff before, sir,

and I know, Mr. Simmons, you've gotten yours at home, but we would like to enter that into the record, the fourth mission story, which we put a good deal, and there are quotes in there from Gen. Kicklighter and many other folks, and we believe it's a pretty balanced article, and let that be part of the record.

Mr. SIMMONS. Without objection, so ordered.

(The provided material follows:)

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4Th Mission

Dealing With A Disaster Surge

BY William Triplett

A small but significant fact went all but unnoticed on September 11, 2001. As emergency fire and medical crews in New York City struggled to help anyone they could find alive amid the cinders and rubble of the collapsed World Trade Center towers, some 68 survivors of the single worst terrorist attack against Americans walked in and registered for attention at the Manhattan VA Medical Center. An additional 30 or so also came in, though they didn't register amid the confusion.

In short, VA doctors and nurses had to deal with about 98 unanticipated cases. The result? "They were overwhelmed," said a congressional expert on veterans affairs. Everyone was eventually treated, but only because more patients did not appear.

The implications of what at first glance might seem merely a detail - a VA hospital emergency room suffered temporary overload - grew ominous as reports of more terrorist attacks later surfaced. Deadly anthrax spores were turning up in the U.S. mail, and while only a minimal number of people died, concern mushroomed about possible biological warfare, or bioterror, attacks aimed at the United States.

Federal, state, and local authorities had conducted a joint exercise involving a bioterrorist incident - with alarming results. A simulated release of aerosolized pneumonic plague bacteria in downtown Denver had wreaked havoc on every level of the emergency response system. Communications broke down as reports of infections spread at breathtaking speed throughout the city, across the country, and then to cities as far away as London and Tokyo because of infected travelers. Stockpiles of antibiotics and other drugs ran out and couldn't be replaced rapidly enough. And every area hospital - including the local VA facility, which participated - was overrun with casualties.

The U.S. government looked closely at the grim lessons learned from the Denver

exercise, conducted in May 2000. Still, the government tended to rank the likelihood of bioterrorism fairly low. Because of the intricacies involved, a credible bioterrorist threat almost would have to involve a state sponsor, and what state would unleash a horror that would draw down the world's condemnation?

"Well, now we've seen a state willing to support that kind of thing," said our congressional source, who asked not to be identified.

No agency, public or private, is more painfully aware of this new, volatile state of affairs than the VA. Federal laws effectively rely on the VA's extensive medical system to play the lead role for governmental assistance in responding to a bioterror disaster anywhere in the United States or its territories. Yet, while a number of other federal agencies have received budget increases to combat terrorism, the VA, by comparison, has gotten almost nothing.

"If 9,800 people had walked into the Manhattan VAMC on September 11 instead of 98, what would they have done?," asked the congressional expert. A bioterrorist attack executed with the precision of the World Trade Center and Pentagon attacks could easily produce upward of 100,000 casualties. And the VA health care system, like the overall American health care industry in the U.S., might not even know what was happening until too late.

"The role of the VA is very important in the event of a biological attack," says Elin Gursky, a senior fellow at the Center for Biodefense Strategy at Johns Hopkins University. For the most part, the VA medical system would be asked to provide "surge capacity," a term health care officials have coined to refer to dealing with the results of a sudden influx of patients who need immediate attention. Most hospitals normally operate at maximum capacity: the more beds that are filled, the more income the hospital generates. As a result, the entire private health care system is vulnerable to a surge in patients.

"We will need additional trained people - physicians, nurses, health care experts - to be able to respond to a surge," Gursky says."We'll need the capacity of VA hospital beds to serve as an overflow for [private and other public] hospitals, and perhaps even be part of a regional triage system, where the VA maybe takes over the less sick patients. In terms of its trained personnel and its facilities, I don't think this country would attempt to do comprehensive bioterrorism planning without VA in an integral role."

The VA has a long history of providing emergency medical assistance throughout the U.S., and with good reason. With 163 medical centers across the country and some kind of clinic in virtually every community, the agency operates the only national health care system that can respond to a domestic medical emergency almost anywhere. Hence, the reason why in 1984 the Department of Defense, Department of Health and Human Services, and the Federal Emergency Management Agency included the VA when drafting plans for the National Disaster Medical System (NDMS). The purpose of the NDMS - jointly operated by DoD, HHS, FEMA and VA - is to provide capability for treating large numbers of patients injured in a large peacetime disaster within the continental United States, or to treat casualties returning from a conventional military conflict overseas.

When the NDMS was first established, DoD had lots of domestic patient beds available. But as DoD downsized, closing many bases, it lost those medical

facilities, leaving VA as the only pre-deployed federal health care resource, meaning it is the only one of the four partner agencies that can provide direct clinical care in the field. Even prior to establishment of the NDMS, VA medical facilities routinely engaged in emergency planning with local private hospitals in their respective areas.

As part of the NDMS, the VA is responsible for running about 80 percent of the federal communications centers, which coordinate response activities with community hospitals in the area of a medical disaster. The VA is also in charge of providing patient care during a disaster, but almost never does that happen within a VAMC. It's usually a matter of working with community hospitals and partners.

In the early 1990s President Clinton wanted the government to be able to protect the country from more than just medical disasters. He issued two directives that eventually formed the backbone of the Federal Response Plan (FRP), which established the architecture for a systematic, coordinated, and effective federal response to any kind of disaster or emergency situation. Under the FRP the VA's responsibilities grew and changed.

The FRP puts two federal agencies in charge - the FBI for crisis management and FEMA for consequence management. FEMA's responsibilities include medical care and public health, both of which are directly overseen by the Department of Health and Human Services, HHS mobilizes the National Disaster Medical System, which then allows the VA to act as an equal partner with HHS. The FRP requires that HHS ask the VA for help and services, which the VA then supplies. Thus, the VA is the main support for mass care.

Because of these plans, the VA has developed a capacity to respond to just about any disaster - and it has. "VA has responded to every single domestic disaster of the last 20 years," says the congressional source. "Hurricane Andrew, Oklahoma City, and even the catastrophic flooding in Houston last year. In fact, the VA hospital in Houston was the only one that did not have a generator in the basement," and was therefore able to keep functioning while generators at other hospitals disappeared under water. For Hurricane Andrew, the agency deployed more than a thousand medical personnel to South Florida.

Then came September 11.

As a result of the temporary overload at the Manhattan VAMC, VA Secretary Anthony Principi established the Emergency Preparedness Working Group (EPWG), a panel of experts charged with determining what the agency must have in place to prevent another overload if a similar attack should occur in the future. Moreover, all VA facilities would have to be able to continue fulfilling their primary mission - caring for veterans - while dealing with a surge in patients.

The EPWG, given short notice and little time because of fears that other terrorist attacks might be imminent, delivered its report last November. "It's quite comprehensive, and it looks at everything from personal protective equipment and decontamination to security and law enforcement," says Dr. Kristi L. Koenig, head of the VA's Emergency Management Strategic Healthcare Group (EMSHG).

"What the [EPWG] found was that VA is in some ways more prepared than the

medical world in general, because they've had to be - VA works all the time with DoD as backup for DoD in times of war," said the congressional source. "Still, things needed to be done."

One thing was an increase in security, training, and equipment at VA medical facilities. VA medical staff had to be able to protect themselves and their patients in the event of an attack. Otherwise, the primary mission of caring for veterans would be jeopardized. "We have to make sure all our facilities are hardened anf that e have continuity-of-operations plans in place so that we can continue providing that care." says Koenig.

What the VA refers to as its fourth mission is an amalgam of responsibilities, such as preparing for the arrival of casualties from an overseas war the U.S. may be fighting or preparing to respond to a domestic disaster. Typically the VA focuses on one of those responsibilities at a time. "But after September 11 all these missions were coming into place at once," says Koenig. For example, while preparing to respond to more attacks on American soil, the agency also had to gear up for the possibility of casualties from the war in Afghanistan. Moreover, the VA also suddenly had to contend with a slightly reduced workforce. "Some of our employees were being called up as reservists," Koenig says.

Consequently, the EPWG recommended a review of virtually all VA emergency and contingency plan the VA had devised to that point to make sure they reflected the new reality.

The EPWG also found, as VA already knew to a large extent, that communication during emergencies was often poor. In particular, it's imperative to develop and use a communication system that does not depend on telephone lines; also, when using radios, a clear plan for everyone to use the same frequency is vital. Information management systems were also discovered to be vulnerable.

The report concluded with an estimate of how much it would cost to bring the VA's level of preparedness up to where it should be - $250 million. "That's actually pretty reasonable," said the congressional source. "But then the administration said, 'Pare that down to what you absolutely have to have.' The group said, 'Okay, we can work with $77 million. We won't be able to do everything, but we can at least get every single VAMC capable of protecting its own patients.' The administration then said, 'Hmm, okay, here's $2 million.' That's all they got from the administration's emergency supplemental funds. The VA has a great plan, but no money. Still, they'll do the job because they have to - they have no choice about protecting veteran patients. But something will lose out. The money will have to come from elsewhere in the VA budget."

The VA already has begun taking steps to improve preparedness. A statement from the agency's office of public affairs says that: "We are enhancing our emergency operations center to keep that system functioning fully in the event of a crisis of any nature. This center has instituted daily, around-the-clock coverage, with secure data and voice communications links, to closely monitor VA's operational status, and to track the location of essential personnel for mobilization in the event of a crisis. Additionally, VA's information technology capability is being improved system-wide.

"Second, to make sure VA can respond fully in the event of a crisis, there will be an immediate review of the [EPWG's] recommendations, identifying those needing immediate action and a fast-track decision process adopted to implement them.

"Third, VA has expanded its Office of Policy and Planning to include operations to support [Office of Homeland Security director Thomas] Ridge in fulfilling the mission of providing for homeland security, and oversee on a daily basis emergency and operations activities."

Specifically concerning the threat of bioterrorism, however, VA's state of preparedness is less encouraging. In theory, the VA would respond on two levels - local and federal. Locally, the VA would provide humanitarian assistance in the form of treating anyone who walked into a VA medical facility. "If someone comes to your door, and he's not a veteran and he's dying on your doorstep, as will happen, you're going to take care of him if you have the ability to do so," says Koenig. "We're not authorized to take care of non-veterans, but in this kind of scenario, we provide humanitarian assistance, and we've done it over and over again already."

This would involve more immediate, almost isolated forms of assistance, as opposed to VA's role on the national level as part of the Federal Response Plan. In a typical emergency, local officials would request help from the state. If the state couldn't provide it, a request would go to the federal level, which would trigger a White House declaration of a disaster, in turn enacting the FRP. More than likely, though, a large release of smallpox bacilli, for example, would automatically activate the FRP. There would be no time for the normal process to work its way up the line: Too many people would die.

The Department of Health and Human Services' office of emergency preparedness would call Koenig's office and make a request for assistance in whatever form - medical personnel or supplies, for instance. "We're not required to provide whatever they ask for," Koenig says. "We only do it if it doesn't degrade our ability to do our primary mission. However, because we have a nationally integrated health care system, up until this point we have generally been able to provide whatever's been requested."

Nevertheless, bioterrorist threats have pointed up shortcomings within the VA and in the country's entire emergency health-care response system. "One of biggest concerns I have is risk communication," says Koenig. "I don't think we did very well with that after the anthrax. We were all still learning, and I'm not sure we gave really good, quick, and clear messages as [the incident] was unfolding. You wouldn't have thought you could contract anthrax the way it was contracted" based on information the government was releasing.

A particularly vexing problem that came out of the simulated release of plague in Denver - an that still has not been resolved - is the question of how to enforce a quarantine. The VA, proactive to a large degree on the matter, had tried to answer this question prior to the Denver test, but it was the Denver test that graphically demonstrated the near-impossibility of restricting the movements of people who may be infected. The only sure means was to shoot them.

From the standpoint of medical response, possibly the most insidious aspect of

bioterrorism is the delayed recognition of a bioterrorist attack. It is not easily determined whether a sudden outbreak of disease is the result of bioterrorism, which more than likely occurs unseen. It's also nearly impossible to know exactly where or when the release of agents took place - and therefore where to send authorities to combat or disinfect it. All you know is that suddenly you have a lot of sick and dying people on your hands.

Currently the VA has no plans to have experts on bioterrorism posted to any of its medical centers. Instead, according to Gen. Mick Kicklighter, the VA assistant secretary for policy and planning as well as the acting director of the agency's Office of Operations Security & Preparedness, existing VA health care personnel will be trained on recognizing and responding to bioterrorist events. "Hopefully we'll get some warnings [of a bioterror attack], but if not, we will have, I believe, a very significant training program connected with this preparedness," Kicklighter says.

"I don't think we'll be getting any new people," adds Dr. Robert Claypool, Kicklighter's deputy. "We'll just be training the people we have. But we are looking at, if the budget supports it, being able to [hire] additional individuals who will have expertise in decontamination training." Ultimately, says Koenig, any decision to bring in resident bioterror experts to any VAMC will be the decision of the VAMC director. "The responsibility for that has been delegated to the individual facilities," she says.

The VA is also participating with other federal agencies to develop something called "syndromic surveillance," which Claypool describes as "a concept where you look at getting an early-warning system or a tripwire for a bioterror event through the recognition of an unusual constellation of symptoms and signs."

But even with bioterror experts located at every VA facility, other preparedness issues remain. "If we had anthrax released in aerosolized fashion, affecting lots more people than were affected last year, causing 500 cases, we could deal with it," says the congressional source. "But 5,000? You just have to look at the number of hospital beds available on any given day to know that that's going to be a problem. A hundred thousand cases of smallpox is numerically possible, but we don't have much play in our medical system - and that's a byproduct of 20 years now of HMO and managed care principles, that we should strip down to minimal inventory, minimal everything, and go to outpatient services. VA's been doing that, too. But VA will be better off than other hospitals in that VA is already putting in place regional pharmaceutical stockpiles just for VA use."

So far the agency has established 143 such stockpiles or caches. According to Claypool, they would allow VA medical facilities to treat anywhere from 1,000 to 2,000 casualties for a day, possibly two, which could be crucial since it will likely take at least that long for the Department of Health and Human Services to release and deliver its supply of pharmaceuticals to an affected area. "The 143 caches are designed specifically to support our medical centers, for patients who present to our centers, for our veterans and for our staff," he says.

Though the VA is designated as a supporting player in a bioterrorist incident, the sheer size and geographic diversity of its medical facilities all but guarantee it will be a lead player on the actual scene. "One thing you can say is that if a bioterrorist attack hit today, VA would end up being involved," the congressional source said. "Because when people get sick, they don't pick up a phone book and say, Which

of the hospitals is best likely to deal with infectious diseases of unknown etiology?' They go to the nearest hospital or where they've always gone. So veterans would go to VAMCs."

But whether the VAMCs will be able to care for them and provide assistance to the communities affected by the attack and continue with the VA's primary mission - caring for veterans - is an open question. A staffing shortage currently plagues the health care industry at large, and the VA is not immune. "Whatever we have to face, we will try to make sure we have minimum disruption in our ability to take care of veterans and their families," says Kicklighter. "If we have excess capability, and the country asks us to help, maybe in bringing resources from other medical centers [not located near the attack], then we'll do everything we can to help save American lives and reduce pain and suffering. Whatever we face, the VA will continue to function as a VA. We won't close down."

Would a VA medical center be authorized, then, to turn away non-veterans should the facility's ability to care for veterans be compromised by an attack in the area? "It's hard to answer a question like that unless you're right on the ground," says Kicklighter. "Our mission is to take care of veterans, but if we're in a situation where we're overwhelmed, we'd just do everything we can to make the right choices and do everything we can to take care of veterans and help our community as much as we could. But in this world, we now have to think of things we never wanted to think of, and massive numbers of casualties, that's one of them."

A U.S. war against Iraq could further strain VA capabilities and resources. A U.S. war against Iraq and a bioterrorist attack on U.S. soil could do far worse. Says Kicklighter, "I think we're moving in the direction to help support our nation in whatever situation there is, whether it's taking battlefield casualties or from the home battlefield, or from both battlefields. But that's a scenario we hope and pray doesn't happen."

The White House has increased the HHS budget anywhere from $3 billion to $6 billion, depending on how you view it, specifically to combat the threat of bioterror. HHS could transfer funds to the VA to pay for any VA services or personnel needed in a national disaster, but HHS is not required to pay for everything it asks from VA. HHS and VA have also had their disputes in the past over allocation of resources. And disputes eat up precious time.

That the VA is supposed to provide only assistance - and not assume the lead role - is no comfort to VA doctors, nurses, and clinicians who know that the rest of the country's emergency health care system is less prepared to deal with mass casualties from bioterror. In practice, the main responsibility will devolve almost instantly to the VA. How long it can hold on until it, too, is overwhelmed is the ultimate question.

"Since probably the 1918 flu pandemic, we've never truly overwhelmed our health care capacity in this country," says Koenig. "We've had major disasters in terms of property damage and death, but live patients with potentially treatable illnesses and symptoms - that's just a lot of theory now. Other countries have had the experience, but not here. It's hard to get people to conceptualize what that would be like."

It may not be so hard one day.

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Mr. WEIDMAN. Thank you very much, sir.

So it's the overall organizational capacity that we believe is dramatically lacking. Even if the 20 million becomes apparent and we have the four preparedness centers created, where the organizational capacity within the VA?

We have already had Secretary Principi into a position where he had to do a triage and cast out, create a new Category 8 and bar them from entering the system, because there are not enough resources there to properly take care of the folks that we have.

That's a tough decision. I had to make it as a medic in Vietnam and I Corps, and there's a more difficult position, and I know that Secretary Principi feels it deeply.

Let's come back to the question, though, of resources. As my distinguished gentleman from PVA, Mr. Blake, just noted that there was an article in the Post yesterday—or yesterday? This week? Tuesday. And in that article, Dr. McKay said there's up to 7,000 beds that will be available for backup to the military medical system.

We're fascinated to know where the heck are those 7,000 beds? VA has, what, 40 percent of the number of in-patient beds and organizational capacity for those beds that it had in 1996, and about 25 percent, 25 to 30 percent of the organizational capacity for inpatients that they had at the end of the last Gulf War.

So we think that the organizational capacity is really out of whack on VA, and that needs to be addressed.

In regard, also, to the bioterrorism, VVA would strongly urge that we speed up the efforts to have an expert on call at least at each and every one of the 168 medical centers in the country that is an expert in bioterrorism and/or chemical exposures, to be able to work with the staff.

The start that VA is now starting to train 85 medical centers is a good start, but it's only a start. It does not cover the nation.

Let me shift my comments in the remaining time I have to the question of pre and post-deployment physicals.

We believe that the law, which is also an attachment, Number 5, to the VVA's statement, is clear as a bell. It says not a darn thing about short questionnaires. It says a physical, a full psychosocial workup, and taking of a blood sample. It has not been done. We think it's clear as a bell.

When we know that Dr. Winkenwerder and all of the folks at DOD are very smart and very fine Americans, it is inexplicable to us that people would ignore and substitute their own judgment for the clear, black letter law of the United States.

As public officers, of course, they were sworn to uphold that law, and you're not supposed to be able to pick and choose, at least not in any course that I ever learned in school.

So we would press hard and urge this committee to work with your colleagues on the Armed Services Committee to ensure that pre-deployment physicals for those who will be deployed, both during the remainder of the way and during the occupation, which nobody is talking very much about, which will have its own set of exposures, that that be done, one.

Two, that adequate, full, post-deployment physicals be done, including blood sample, including a full psycho-social workup, and

what vaccines, et cetera, that that person has gone through, that those be taken, and a blood sample not only made available, all of that physical, including the samples, to DOD, but to the VA and to that individual to use however he or she wants to do private testing about what may have happened to him or her while overseas.

Three——

Mr. SIMMONS. I thank the gentleman for his statement. If you could wrap it up?

Mr. WEIDMAN. I'm sorry. I apologize.

Mr. SIMMONS. Yes. Thank you.

Mr. WEIDMAN. The last point I would want to make, sir, is that the war-related injury and illness study centers need to be greatly expanded, both in terms of their authority throughout the system—they are not publicized outside of Washington, DC and East Orange, New Jersey. Most people in VA, never mind the veterans who use the VA, do not know that they exist.

This needs to be greatly expanded and those men and women who are serving overseas today, whether in the Philippines or in Southwest Asia, need to know that this exists, and when they go to the VA, if they're not immediately turned on to it, that they can then say, "I want to go and/or be seen by the war-related injury and illness study center, because I believe I have something due to exposure."

[The prepared statement of Mr. Weidman, with attachments, appears on p. 127.]

Mr. SIMMONS. Thank you, and welcome home.

Now to the questions.

The first question, Mr. Weidman, Page 2 of your testimony, the third paragraph from the bottom, there's a statement, "respectfully disagreeing with the leadership," et cetera, et cetera, et cetera.

Is that language from another testimony, by any chance? Is that language that might have been taken from testimony before the Appropriations Committee?

The reason I ask is that if you read the language all the way through, it is not consistent with the position that was taken by this subcommittee and this committee on that issue, so I wonder if that didn't creep in in error.

If you could take a look at that and clarify it?

Mr. WEIDMAN. That first sentence is—the first part of that first sentence is mistaken, and I apologize for that, sir, and with your permission, would have that stricken and corrected for the record.

Mr. SIMMONS. I agree with that, and I know that sometimes through the miracle of modern word processing, sometimes we rework our materials, but it occurred to me that the thrust of that comment did not apply to this committee.

Mr. WEIDMAN. Actually, I did not borrow from previous testimony.

Mr. SIMMONS. Oh, you didn't?

Mr. WEIDMAN. It's just I am, as they say, technologically challenged, sir.

Mr. SIMMONS. Okay. Thank you very much.

The second question is to all members of the panel, to respond as they see fit.

We've talked about the issue of four sites to be involved in bioterrorism research and to be involved in planning responses to the threat of bioterrorism, and that seemed like a reasonable number at the time. Whenever we try to initiate new programs, we try to start, you know, relatively small, I guess you could say.

But given the fact of where we are, given the fact of what we've uncovered thus far in the war in Iraq—3,000 suits, atropine vials, et cetera, et cetera, the threat of chemical/biological weapons being used by the chief of state, Saddam Hussein, the evidence that these weapons are out there—do we think that four centers would be sufficient to do this work if we were able to move forward and fund this initiative?

Would four centers do it, or is another number better in line with the reality of the problem we face?

Mr. GAYTAN. Speaking on behalf of the American Legion, we would first like to see the four centers funded and developed and built and serviced and provided with what they need to accomplish their mission.

So to speculate any further, I honestly, as a citizen of this country, hope that, no, we don't need four more; but as a member of the American Legion and speaking on behalf of the American Legion, I think we need to start with four. That's going to be struggle enough.

It's obvious that the law was passed, the funding wasn't provided, we're back here reminding of the importance of these facilities. We're going to have to assess our mission, and our mission is to make sure we get the first four.

Mr. SIMMONS. Does anyone else want to comment?

Mr. WEIDMAN. VVA has contended for a long time, as you know, Mr. Chairman, that there is a need for, under another jurisdiction within the Congress, to create a National Institute for Veterans and Military Health at the National Institutes of Health.

These four centers may, in fact, be enough if we're talking about research and research conducted for it from these four centers.

The issue here is training of all staff and clinicians and researchers everywhere under the auspices of these four centers which, frankly, we would hope would have one consolidated management structure, if you will, reporting acknowledge to Dr. Ray, but not in the sense of over-controlling, but then doing RFPs within the VA that a researcher at some place not one of those four centers could apply to do clinical research in this regard, and coordinate that with what we really need, a National Institute for Veterans and Military Health at the NIH.

Mr. SIMMONS. Thank you.

Mr. BLAKE. Mr. Chairman, I would just like to concur with Mr. Gaytan from the Legion. I don't think you could say it much better than that. We need to focus on the priority first, which is to fund what is already created.

To say what a number would be that would actually be needed, one, PVA wouldn't even want to begin to speculate, because then you start getting into the possibility of something that could be a tragic situation, and we would never go that direction.

But, given the possibility down the line, that may be a necessary direction to go, to create more of these centers, but as it stands,

the first four have not even been funded, so we need to focus our efforts there first.

Mr. SIMMONS. I thank the gentlemen. I yield back my time.

Mr. Rodriguez.

Mr. RODRIGUEZ. Let me just follow up on that.

I want to first of all thank all four of you, and let me know if I'm wrong, but all four of you are supportive of pushing forward on those emergency response centers throughout this country, and I think that that, as a minimum, is something that we ought to respond to.

I was visiting one of the hospitals Israel, and one of the first things they told me is that in case of a biological/chemical attack, you know, that they have to take them through some process before they ever get admitted to the hospital, which, when I went to my VA hospital in San Antonio, we're not there yet.

So there's a great deal of training that needs to take place, and if anyone should be trained initially as to how to handle combat situations, it's the VA medical response area.

My concern is that when it comes to the new agency, the homeland defense, you know, with all due respect to that secretary, his main responsibility is taking care of those 26 agencies underneath that particular secretary, and I don't know, and I'm going to have to look at, because I know it deals with the Coast Guard and a whole bunch of others, but we have, you know, a system now nationwide of health facilities under the VA that can really be—you know, and those are the ones that are going to be, in case a problem occurs, they're going to be assisting in case something develops out there, and those medical response teams are going to be the first ones there, and so not any other federal office or anything.

So I think I wanted to ask you, because I know our thinking is that next week or the following week, and I've mentioned it to the chairman, the supplemental is coming over, and if we're going to fund this in any way, it almost has to be through the supplemental, because it's going to be tough.

And I was going to ask if you would be willing to get—you know, because we might move on that next week, and kind of push forward on the supplemental some money to make this happen, and I was going to ask you if you felt—you know, you don't have to respond—but if we could utilize your support in doing that.

Mr. GAYTAN. I do know the American Legion is dedicated to ensuring that that law is enacted, and part of that would be any support you need from the American Legion to provide funding in the supplemental, we're right behind you, sir.

Mr. RODRIGUEZ. So I can say that you're with me in terms of making it happen on the supplemental?

Mr. GAYTAN. Yes, sir.

Mr. RODRIGUEZ. DAV?

Mr. ATIZADO. Yes, sir. As I said previously, we have and still continue to support the mandates of the law. It's just good to see that there is action being taken on the latter half of the law, which is to actually allocate funds which were authorized when the public law became effective.

I think we should understand, sir, that the VA is caught in two specific instances. They're a primary backup for DOD and they're

also a primary backup for the American public, the public health care system.

I think it would behoove us to move on our initiatives here. Otherwise, we don't want to get caught in a position where we don't have something that the American public thought we did.

Thank you.

Mr. BLAKE. Congressman Rodriguez, I know PVA would certainly support efforts to get funding for the VA through the supplemental.

We've spent—our organization particularly has been trying to lead an effort to get funding for the VA's fourth mission for the last year-and-a-half, since September the 11th.

We had numerous meetings on the Hill last year. We talked to all of the appropriators. We stressed the need to have that $250 million, which Secretary Principi discussed on more than one occasion, for the fourth mission, and there was no sign of any money to be provided for that particular mission at any point last year.

I'd also like to emphasize that we've always said that money for the fourth mission should be a separate line item, as DAV mentioned in its testimony, it should not be considered as a sub-category, say, of VHA. That's a separate situation in and of itself, and the fourth mission should be considered independent of all those other programs within the VA.

Mr. WEIDMAN. Mr. Rodriguez, the VVA is deeply committed to seeing these centers get moving, and we expand that to training, proper training, in how to handle these kinds of casualties, mass civilian casualties at all 168 medical centers across the country. We're way behind the curve on this.

As an example, on the Veterans' Health Initiative, there should be a chemical weapons curriculum available to all VA employees and a biological weapons curriculum, and a dirty nukes, you know, et cetera, et cetera.

We would note, however, that money has already been appropriated by the Congress. In the fall of 2001, $20 billion was immediately appropriated and given to the President. VA requested 77 million of that 20 billion. I double checked yesterday with the chief fiscal officer for VHA, and not a doggoned dime of that went to VA.

This full 20 million can come out of that 20 billion, which, as we recall, was non-year-specific money, and therefore it didn't go away at the end of the fiscal year, and we could get moving on this if, in fact, it is a national priority to prepare to take care of the American populace in case of chemical and biological terrorism attacks, whether those occur in Florida or in Texas or in Connecticut.

And it would seem to us, instead of fighting a conceptual battle, that that's where the money ought to come from to get things moving at this moment while we develop another way of funding it, perhaps through homeland security.

Mr. RODRIGUEZ. Thank you.

Mr. SIMMONS. I thank the gentleman for his questions.

Vice chairman, Mr. Moran, followed by Mr. Strickland.

Mr. MORAN. Mr. Chairman, thank you very much.

I just would ask the panelists if they have thoughts of kind of what questions should we be asking the Department of Defense and the Department of Veterans Affairs in regard to the safety and health and wellbeing of our troops now deployed, and do they have

a sense that things are different than they were in the way that we're handling these issues, different than they were during the Persian Gulf war.

Can we expect our men and women to return, the service men and women of today who will be participants in the VA system in the future, can we expect them to return home in circumstances different than what we experienced post-Persian Gulf war?

Mr. GAYTAN. Well, sir, I thank you for posing that question, and I also want to comment that the questions that you did ask DOD earlier were very relevant. I think we need to ensure that they respond with a logical answer and explanation of exactly what they're doing.

I don't think I made the specific point that I wanted to in my oral testimony on the importance of DOD/VA collaboration in recording exposure and health issues for deployed personnel pre-deployment, during deployment, and post-deployment.

The fact that the law requires, as Mr. Weidman mentioned, actual physicals, blood samples—and what was the third?

Mr. WEIDMAN. Psycho-social workups.

Mr. GAYTAN. Psycho-social workups. Those are three requirements by law that DOD must meet for the returning servicemembers.

Right now, as I mentioned, there are two questionnaires, and I have copies of each of those questionnaires, DD forms, that are being used instead of full physicals, blood samples, and a psycho-social workup. The blood samples that DOD is relying on as a requirement of that law are HIV blood samples that are taken by servicemembers. They are categorizing that as the blood sample that's supposed to be used for returning servicemembers.

I think, sir, a question that needs to be asked of DOD is an exact explanation of exactly what's going on for these servicemembers, what they're receiving pre, during, and post-deployment, exactly what's going on, not that they are committed to doing this, but exactly what is Joe Servicemember receiving pre, during, and post-deployment. I think that's a good start.

Mr. MORAN. I appreciate that, is what I'm trying to get at, because often, the answers we receive are, "We're working on this, we're making progress, it's our policy, we're better off today than we were," but specifically, are there things that are not being done that need to be done?

Mr. GAYTAN. I honestly think that's a good start, sir.

Mr. WEIDMAN. The answer to that question, at least from our point of view, sir, is how successful you, sir, and your distinguished colleagues from this committee and from the Armed Services Committee are in pressing DOD to comply fully with the law and ensure that there is a complete post-deployment physical, and that that information, including access to the blood sample, be of sufficient size that the individual American citizen who is serving in the military has access to that blood sample for private testing, or, if they wish to direct it, go to a VA testing person.

The point about it is that that would make a tremendous difference. Not doing the pre and post is going to dramatically affect these fine men and women who are in harm's way now if, in fact, they have to try and prove that some kind of physiological problem

that they have, or psychological problem that there may be, was due to their deployment in Southwest Asia; and that was the whole point that the Congress had as an intent in passing that kind of specific requirement.

The second thing is that is the VA ready? No, the VA is, in fact, in much worse shape in terms of organizational capacity, in terms of numbers of doctors, nurses, allied health care people, than they were in 1991, a dramatically different kind of a situation, and therefore—and is already an overloaded system that is virtually collapsing under the demand that's placed upon it right now, never mind trying to fulfill the fourth mission, which may in fact happen before these folks come home from Southwest Asia, the Philippines, or wherever they are, and never mind the overload of veterans who are already in the system and trying to properly meet their needs.

So there are a couple of things that we have recommended that have not been done. Let me give you just one small example.

Mental health capacity—it's not small, it's a big one. Mental health capacity has been dramatically sliced to ribbons since 1996, all over the country, in every VISN. Some VISNs are worse than others, but every one has been cut.

In addition to that, the vet centers have not had an increase in well over a decade, not for inflation, not for nothing, and there's more vet centers today than there were then. That is really the forward aid station, if you will, on neuropsychiatric wounds.

As many of us in this room know who have been on the battlefield, you're changed forever. It doesn't mean you have PTSD that can't be resolved, and it doesn't mean you can't move onto a productive life, but that vet center becomes a vital thing in helping people quickly adjust and get on with their lives.

We, for the last 2 years, have recommended additional staff for those vet centers, and approximately $18 million, and none of that has been forthcoming. Something that could be done very fast is directing the VA to channel that $18 million into those 206 vet centers around the country as a first line of defense against—and screening to pull people into the VA system.

And in the short run, that would be that the overall question of organizational capacity, Mr. Moran, is something that we really have to change the context on and continue to work together to educate everyone in the Congress as well as the American people.

Mr. MORAN. My time has expired. Thank you, Mr. Chairman.

I just would offer you the opportunity to submit to me any questions you would like to have asked of the DOD or the VA, because I'd like to follow up with them with my own questions in writing.

Thank you.

Mr. SIMMONS. Thank you. Mr. Strickland.

Mr. STRICKLAND. Thank you, Mr. Chairman.

Listening to the questions and listening to the answers, it seems obvious to me that the ultimate solution to all of our concerns is more resources, more money. This system needs to be better funded.

But I have here these Forms 2795 and 2796, these self-report examinations, if you will, and I want to ask you if you can answer a question for me.

At the end of this section that is supposed to be filled out, it appears, by the serviceperson, there's a section, Post-deployment Health Provider Review, for Health Provider Use Only," and there's this statement:

"After interview/exam of patient, the following problems were noted and characterized," and so on.

Help me understand. Is everyone who fills out these forms seen by a physician?

Mr. ATIZADO. No, sir.

Mr. STRICKLAND. So they are not?

Mr. ATIZADO. No, sir. In fact, as I mentioned earlier in my testimony to the subcommittee, I believe it was the—on Tuesday, the second panel before the Subcommittee on National Security, Emerging Threats, and International Relations.

The second panel consisted of Dr. Moxley, Managing Director, North American Health Care Division; and Dr. Manning Feinlieb, Professor of Epidemiology at Bloomberg School of Public Health; and Mr. Steve Robinson, Executive Director, National Gulf War Resource Center.

The bulk of their discussions with the subcommittee dealt with the questionnaire.

Dr. Manning Feinlieb, I believe—and I'm going to paraphrase or summarize what was discussed—was that the questions that were asked on the questionnaires, if you look at it from the perspective of a servicemember who is about ready to be deployed, how does one answer yes or no to these questions if their fellow servicemembers, who he has trained with day in, day out for the past who knows how many years, how that servicemember would answer those questions when his fellow servicemembers are about to be deployed, without him, possibly?

And the second thing that was brought up, sir, was their concern that what use was the questions being asked? In fact, I believe there was a third of the pre-deployment questions had any tie to the post-deployment questions—a third.

Concern was raised whether or not the purpose of the questionnaire would actually be sufficient to initiate an epidemiological study.

Mr. STRICKLAND. Sure. What I'm getting at here, there's a place for the serviceperson to sign, "I certify that responses on this form are true," and they're asked to sign; and then, at the bottom, "I certify that this review process has been completed," provide your signature and stamp.

So is every person who fills one of these out at least interviewed by a physician?

Mr. ATIZADO. No, sir. I believe one of the recommendations that panel made was to, in fact, utilize a computer to be able to institute secondary questions.

Mr. STRICKLAND. You know, I'm just wondering about a health care provider that would be willing to sign his or her name indicating that they had reviewed this process.

As a health care provider myself, before coming to Congress, I would be very hesitant to put my signature on such a form if I had not had some direct interaction with the person that had filled out the form.

Mr. WEIDMAN. If I may add to that, Mr. Strickland?

Mr. STRICKLAND. Sure.

Mr. WEIDMAN. One-third of the forms are returned incomplete. They didn't even bother filling out the whole thing. It's not, by and large, done by a physician or even an examining, not a one-on-one process. It's done in a group.

They pass out the questionnaires to a large group, people fill them out and either complete them or don't, and turn them back in and, you know, you have your basic E–2 in charge signing off that this happened. So it's not a good way to run a railroad.

We would make note, however, and would suggest, if I may, Mr. Strickland, that you take those two forms, pre and post forms—which incidentally we believe not just on our opinion, we've checked with epidemiologists, believe that these forms are absolutely, utterly useless from an epidemiological point of view—enter those into the record so people reading the web site can make their own judgment.

And secondly, I have in my possession a copy of a form that would be a much more respectable form that was developed by researchers and the Rhode Island National Guard, and proposed to use that for a study of National Guard and Reserves activated from New England, and have heretofore been refused access to their own troops who have now been federalized in order to administer these forms and provide the baseline.

(The material follows:)

33348

POST-DEPLOYMENT Health Assessment

Authority: 10 U.S.C. 136 Chapter 55. 1074f, 3013, 5013, 8013 and E.O. 9397

Principal Purpose: To assess your state of health after deployment outside the United States in support of military operations and to assist military healthcare providers in identifying and providing present and future medical care to you.

Routine Use: To other Federal and State agencies and civilian healthcare providers, as necessary, in order to provide necessary medical care and treatment.

Disclosure: **(Military personel and DoD civilian Employees Only)** Voluntary. If not provided, healthcare WILL BE furnished, but comprehensive care may not be possible.

INSTRUCTIONS: Please read each question completely and carefully before marking your selections. Provide a response for each question. If you do not understand a question, ask the administrator.

Demographics

Last Name

First Name **MI**

Deployed Unit

Today's Date (dd/mm/yyyy) / /

Social Security Number - -

DOB (dd/mm/yyyy) / /

Date of arrival in theater (dd/mm/yyyy) / /

Date of departure from theater (dd/mm/yyyy) / /

Gender

- O Male
- O Female

Service Branch

- O Air Force
- O Army
- O Coast Guard
- O Marine Corps
- O Navy
- O Other

Component

- O Active Duty
- O National Guard
- O Reserves
- O Civilian Government Employee

Pay Grade

O E1	O O1	O W1
O E2	O O2	O W2
O E3	O O3	O W3
O E4	O O4	O W4
O E5	O O5	O W5
O E6	O O6	O Other
O E7	O O7	
O E8	O O8	
O E9	O O9	
	O O10	

Location of Operation

- O Europe
- O SW Asia
- O SE Asia
- O Asia (Other)
- O South America
- O Australia
- O Africa
- O Central America
- O Unknown

Deployment Location (CITY, TOWN, or BASE):

List country (IF KNOWN):

Name of Operation:

Administrator Use Only

Indicate the status of each of the following:

Yes	No	N/A	
O	O	O	Medical threat debriefing completed
O	O	O	Medical information sheet distributed
O	O	O	Post-Deployment serum specimen collected, if required

33348

PLEASE FILL IN SOCIAL SECURITY # ☐☐☐ - ☐☐ - ☐☐☐☐

Health Assessment

1. Would you say your health in general is: O Excellent O Very Good O Good O Fair O Poor
2. Do you have any unresolved medical or dental problems that developed during this deployment? O Yes O No
3. Are you currently on a profile or light duty? O Yes O No
4. During this deployment have you sought, or intend to seek, counseling or care for your mental health? O Yes O No
5. Do you have concerns about possible exposures or events during this deployment that you feel may affect your health? O Yes O No

   Please list your concerns: _____

   _____
6. Do you currently have any questions or concerns about your health? O Yes O No

   Please list your concerns: _____

   _____

Service Member Signature

I certify that responses on this form are true. ☐

Post-Deployment Health Provider Review (For Health Provider Use Only)

After interview/exam of patient, the following problems were noted and categorized by Review of Systems. More than one may be noted for patients with multiple problems. Further documentation of problem to be placed in medical records.

REFERRAL INDICATED

O None
O Cardiac
O Combat / Operational Stress Reaction
O Dental
O Dermatologic
O ENT
O Eye
O Family Problems
O Fatigue, Malaise, Multisystem complaint
O GI
O GU
O GYN
O Mental Health
O Neurologic
O Orthopedic
O Pregnancy
O Pulmonary
O Other _____

EXPOSURE CONCERNS (During deployment)

Provider see questions 5&6 on this form

O Environmental
O Occupational
O Combat or mission related
O None

Comments: _____

_____

_____

I certify that this review process has been completed.

Provider's signature and stamp: ☐

Date (dd/mm/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

End of Health Review

33348

DD FORM 2796, MAY 1999 ASD (HA) APPROVED SEPTEMBER 1998 Ver 1.3

33823

PRE-DEPLOYMENT Health Assessment

Authority: 10 U.S.C. 136 Chapter 55. 1074f, 3013, 5013, 8013 and E.O. 9397

Principal Purpose: To assess your state of health before possible deployment outside the United States in support of military operations and to assist military healthcare providers in identifying and providing present and future medical care to you.

Routine Use: To other Federal and State agencies and civilian healthcare providers, as necessary, in order to provide necessary medical care and treatment.

Disclosure: **(Military personel and DoD civilian Employees Only)** Voluntary. If not provided, healthcare WILL BE furnished, but comprehensive care may not be possible.

INSTRUCTIONS: Please read each question completely and carefully before marking your selections. Provide a response for each question. If you do not understand a question, ask the administrator.

Demographics

Last Name

First Name **MI**

Deploying Unit

Today's Date (dd/mm/yyyy) / /

Social Security Number - -

DOB (dd/mm/yyyy) / /

Gender

- O Male
- O Female

Service Branch

- O Air Force
- O Army
- O Coast Guard
- O Marine Corps
- O Navy
- O Other

Component

- O Active Duty
- O National Guard
- O Reserves
- O Civilian Government Employee

Pay Grade

- O E1
- O E2
- O E3
- O E4
- O E5
- O E6
- O E7
- O E8
- O E9
- O O1
- O O2
- O O3
- O O4
- O O5
- O O6
- O O7
- O O8
- O O9
- O O10
- O W1
- O W2
- O W3
- O W4
- O W5
- O Other

Location of Operation

- O Europe
- O SW Asia
- O SE Asia
- O Asia (Other)
- O South America
- O Australia
- O Africa
- O Central America
- O Unknown

Deployment Location (IF KNOWN) (CITY, TOWN, or BASE):

List country (IF KNOWN):

Name of Operation:

Administrator Use Only

Indicate the status of each of the following:

Yes	No	N/A	
O	O	O	Medical threat briefing completed
O	O	O	Medical information sheet distributed
O	O	O	Serum for HIV drawn within 12 months
O	O	O	Immunizations current
O	O	O	PPD screening within 24 months

33823

PLEASE FILL IN SOCIAL SECURITY # ☐☐☐ - ☐☐ - ☐☐☐☐

Health Assessment

1. Would you say your health in general is:	O Excellent	O Very Good	O Good	O Fair	O Poor
2. Do you have any medical or dental problems?				O Yes	O No
3. Are you currently on a profile, or light duty, or are you undergoing a medical board?				O Yes	O No
4. Are you pregnant? (FEMALES ONLY)			O Don't Know	O Yes	O No
5. Do you have a 90-day supply of your prescription medication or birth control pills?			O N/A	O Yes	O No
6. Do you have two pairs of prescription glasses (if worn) and any other personal medical equipment?			O N/A	O Yes	O No
7. During the past year, have you sought counseling or care for your mental health?				O Yes	O No
8. Do you currently have any questions or concerns about your health?				O Yes	O No

Please list your concerns: _____

_____

Service Member Signature

I certify that responses on this form are true. ☐

Pre-Deployment Health Provider Review (For Health Provider Use Only)

After interview/exam of patient, the following problems were noted and categorized by Review of Systems. More than one may be noted for patients with multiple problems. Further documentation of problem to be placed in medical records.

REFERRAL INDICATED

- O None
- O Cardiac
- O Combat / Operational Stress Reaction
- O Dental
- O Dermatologic
- O ENT
- O Eye
- O Family Problems
- O Fatigue, Malaise, Multisystem complaint
- O GI
- O GU
- O GYN
- O Mental Health
- O Neurologic
- O Orthopedic
- O Pregnancy
- O Pulmonary
- O Other _____

FINAL MEDICAL DISPOSITION: O **Deployable** O **Not Deployable**

Comments: (If not deployable, explain)

_____

_____

_____

I certify that this review process has been completed.

Provider's signature and stamp: ☐

Date (dd/mm/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

End of Health Review

Mr. WEIDMAN. So it's not just a question that they think that they're not doing the baseline. They're preventing others who want to establish a baseline for these troops from doing so, and that, sir, we believe is a wilful act of calumny.

Mr. STRICKLAND. I want to thank you for your testimony, and I have to apologize. I've got a second committee having a hearing on this same subject, and I must break away and go to that hearing.

So thank you, Mr. Chairman.

Mr. BLAKE. Congressman Strickland, might I add one thing—Mr. Chairman, can I just add one thing quickly?

Mr. SIMMONS. Of course.

Mr. BLAKE. Having gone through a very similar process not too long ago, since I'm recently out of the service, I can say from my perspective, the way it seemed that it was handled when I was in the active duty Army, in many cases, the forms were just collected and then those forms could just be signed by either a brigade or battalion medical officer or they may be just forwarded to your medical clinic which was responsible for your unit, and where they went from there was anybody's guess.

Mr. SIMMONS. I want to thank the panel. We are now ready for the third panel; and I thank Mr. Strickland for his questions and his participation. That's very helpful.

The third panel is made up of four members, one of whom, Dr. Shanley, from my state university, the University of Connecticut, has been delayed in his travel arrangements.

He is the director of the Division of Infectious Diseases at the UCONN Health Center, and he's also the Connecticut State Chairman of Infectious Diseases.

We also have Dr. Lawrence Feldman, Vice President, the University of Medicine and Dentistry in New Jersey. Welcome.

We have Dr. Harold Timboe, Associate Vice President for Administration, University of Texas Health Science Center at Houston.

And Dr. Thomas Terndrup, Director of the Center for Disaster Preparedness, Department of Emergency Medicine, University of Alabama at Birmingham.

Gentlemen, thank you for being here today, and because one of our panelists is from the great State of Texas, I would ask if the ranking member would like to give his own personal welcome.

Mr. RODRIGUEZ. Welcome, and let me also just indicate, because of the fact that you don't see the other members here, we've got two or three committees going at one time, and I know there was a hearing on POWs.

So we welcome all of you here. Thank you very much.

Mr. SIMMONS. Thank you, gentlemen. If Dr. Shanley fails to show up, I ask unanimous consent that his testimony be inserted into the record. Hearing no objection, that will be so ordered.

[The statement of John D. Shanley appears on p. 143.]

Mr. SIMMONS. Gentlemen, you've been sitting through this hearing. I think you have a sense of where we're going and what our concerns are.

Thank you for coming, especially those of you who have traveled a great distance, and we look forward to your testimony.

Why don't we begin with Dr. Feldman.

STATEMENTS OF LAWRENCE A. FELDMAN, PH.D., VICE PRESIDENT, UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY; HAROLD L. TIMBOE, M.D., MPH, ASSOCIATE VICE PRESIDENT FOR ADMINISTRATION, UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT SAN ANTONIO AND DIRECTOR, CENTER FOR PUBLIC HEALTH PREPAREDNESS AND BIOMEDICAL RESEARCH, UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT SAN ANTONIO; AND THOMAS E. TERNDRUP, M.D., FACEP, DIRECTOR AND CHAIR, DEPARTMENT OF EMERGENCY MEDICINE, UNIVERSITY OF ALABAMA SCHOOL OF MEDICINE AND DIRECTOR, CENTER FOR DISASTER PREPAREDNESS, DEPARTMENT OF EMERGENCY MEDICINE, UNIVERSITY OF ALABAMA AT BIRMINGHAM

STATEMENT OF LAWRENCE A. FELDMAN

Mr. FELDMAN. Thank you, Mr. Chairman. It's a pleasure for me to be here today.

The University of Medicine and Dentistry of New Jersey, UMDNJ, is the largest freestanding public university of the health sciences in the nation. The university is located on five statewide campuses and contains three medical schools and schools of dentistry, nursing, health-related professions, public health, and graduate biomedical sciences.

UMDNJ comprises a university-owned acute care hospital, three core teaching hospitals, an integrated behavioral health care delivery system, a statewide system for managed care, and affiliations with more than 200 health care and educational institutions across the state of New Jersey.

We congratulate Chairman Chris Smith and this committee for securing the passage of Public Law 107–287, the Department of Veterans Affairs Emergency Preparedness Act of 2002.

This legislation recognizes our nation's continued vulnerability to biological, chemical, or radiological attack and the unique resources that exist within the Veterans Administration and our nation's medical and health professional schools to better prepare for these contingencies.

Today, as our nation commits its military forces to defend freedom in Iraq, our brave soldiers lay exposed to the potential of biological or chemical attack. Once returned home, our Veterans Administration hospitals will be called upon to provide the care needed to return our veterans to productive lives.

The new statute recognizes that many diseases and toxins that terrorists might use are not seen in the normal course of civilian medical practice, and only rarely in the military environment.

Regional preparedness centers created under the new law join the resources of VA medical centers with schools of medicine, public health, allied health, and nursing to work cooperatively in developing research and educational programs to respond to terrorist and other public health threats.

The designated preparedness centers would provide training to VA staff community physicians, and other health care professionals in the diagnosis and treatment of injuries or illnesses induced by exposures to chemical and biological substances, radiation, and incendiary or other explosive weapons or devices.

In this way, the VA Emergency Preparedness Act leverages the strong affiliations that exist between VA medical centers and many of our nation's schools of medicine.

For example, the VA New Jersey Health Care System is a major training site for UMDNJ students and graduates. Medical students and residents, as well as medical, nursing, and allied health undergraduates participate in clinical rotations and clerkships within the Lyons and East Orange VA facilities to enhance their clinical skills and knowledge while delivering health care service to veterans?

The training of physicians and other health care professionals in the diagnosis and treatment of illnesses caused by exposure to biological and chemical substances, as provided in the new statute, is an integral, natural, and critical expansion of the mission of the nation's health professions schools.

UMDNJ—New Jersey Medical School—has provided training in bioterrorism-related issues to its graduate students for several years.

UMD and Rutgers University jointly sponsor an NIH/National Institute of Environmental Health Science National Center of Excellence, known as the Environmental and Occupational Health Sciences Institute, considered to be one of the nation's foremost programs in education and training concerning chemical and other environmental threats. In fact, this institute was involved in the aftermath of 9/11 in New York.

Faculty at EOHSI are already working closely with the VA to develop educational modules on exposure-related chronic illnesses. The creation of regional VA preparedness centers could more effectively leverage these existing resources to enhance the education and preparedness of our nation's medical and public health communities.

Regional VA preparedness centers would also be called upon to increase our nation's capacity for carrying out research on the detection, diagnosis, prevention, and treatment of injuries and illness related to exposure to chemical, biological, or radiological toxins. These centers would engage in direct research and coordinate their activities with affiliated schools of medicine, schools of public health, and other public and private agencies to leverage existing resources and activities.

For example, as New Jersey's only academic health center, UMDNJ offers an integrated network of basic and applied research that addresses the health implications of exposure to biological and chemical weaponry. At its Biosafety Level 3 laboratory, the UMDNJ Center for Biodefense is conducting research to better understand the human immune response to infection by a wide range of agents.

As one of the two war-related illness and injury study centers created by the VA, the East Orange campus of the Veterans Administration New Jersey Health Care System is collaborating with faculty at UMDNJ to increase the understanding of the medically unexplained symptoms of veterans deployed to combat areas. UMDNJ and VA collaborations extend to many other areas, including the medical consequences of stress.

UMDNJ and the VA New Jersey Health Care System enjoy many other close affiliations in research, education , and health

care that would provide critical support in meeting the objectives of the statute to enhance our nation's preparedness.

We congratulate the full committee and Chairman Smith in securing the $20 million in budget authority within the veterans portion of the House Budget Resolution, providing sufficient budget allowance for first-year funding to establish four national emergency preparedness centers.

We urge the Congress to complete this job and provide the necessary support for the full implementation of Public Law 107–287. The time to enhance our nation's preparedness for biological and chemical attack is now, and the VA, together with affiliated schools of medicine, offers significant resources and assets to meet these objectives.

This bill offers a tremendous opportunity to lead two vital players in defense of our nation against bioterrorism, and we enthusiastically support its implementation.

Thank you for this opportunity to appear before the committee.

Mr. SIMMONS. Thank you, Dr. Feldman.

Our next witness is Dr. Timboe. I note for the record that he served 34 years in our nation's military and recently retired as the commanding general of Walter Reed Army Medical Center.

It's good to have you here. Feel free to summarize your statement if you wish, Dr. Timboe. Thank you.

STATEMENT OF HAROLD L. TIMBOE

Dr. TIMBOE. Thank you very much, Mr. Chairman, members.

I appreciate the opportunity to address the committee in support of implementing the Department of Veterans Affairs Emergency Preparedness Act of 2002.

Also, on behalf of President Francisco Cigarroa, I want to thank Congressman Ciro Rodriguez for his leadership in passing this law and for inviting me to appear before this committee.

I am Dr. Harold Timboe, Director of our Center for Public Health Preparedness and Biomedical Research at the University of Texas Health Science Center at San Antonio, and today I am representing Dr. Cigarroa, President of the University and a member of Secretary Tommy Thompson's National Advisory Council on Public Health Preparedness.

The health science center that I represent is one of the largest and most comprehensive health science universities in the country, educationing the next generation of professional health care teams. We have three campuses in San Antonio and three campuses along the Rio Grande River, impacting several hundred miles of the U.S.-Mexico border.

We collaborate closely with the renowned military medical centers in San Antonio, many public and private health organizations throughout South Texas, and the South Texas Veterans Health Care System led by Mr. Jose Coronado. We truly have a unique mission, impact, and opportunities among the nation's health science universities.

On behalf of Dr. Cigarroa and Mr. Coronado, we applaud Congress's enactment of Public Law 107–287 which recognizes the responsibility and tremendous impact we feel that the assets of the

Department of Veterans Affairs can have on the health and preparedness of our nation.

Thomas Jefferson said 200 years ago that, "The health of the people is really the foundation upon which their happiness and the power of the state depend." With the new threats and vulnerabilities we face, that statement is more pertinent today than it ever has been. The public's health preparedness is of vital national interest.

We see responses at all levels to improve our public health emergency response capabilities as well as the biomedical research essential to giving us better products with which to protect our people.

It is very appropriate that the Veterans Health Administration, as the nation's largest and most geographically dispersed health system, contributes its considerable resources and talents to the problems we all now face.

We've all had long, mutually-beneficial relationships. This is true in San Antonio with the Audie Murphy VA Hospital as well. I went to medical school there and know its clinical excellence in teaching 25 years ago, and today I work with them closely in our regional emergency preparedness planning.

In fact, we have set up the Federal Coordinating Center for the National Disaster Medical System. We will be receiving casualties from Iraq and we have been from Afghanistan, into San Antonio. The VA there is responsible for coordinating that. They set up their regional operations center right on our campus of our health science center.

So we're very proud of the very collegial relationships we have in education, service delivery, and in research between DOD, VA, and the university.

One of the main challenges our public health emergency response plans face is filling in the requirements in the new manpower gaps that the casualty estimates brought on by vulnerabilities from weapons of mass destruction and threats heretofore addressed by the nation's military forces, but now potentially directly impacting our communities at home—communities both large and small.

Where in the past, local and regional plans generally considered casualties in the hundreds, now they must address estimates exceeding several thousand or more. This is indeed a new era, and the VA can help with building clinical surge capacity, some of which must be mobile.

You've heard a little bit of my background in the military. I experienced more than a handful of mass casualty situations with at least 100 injured, including the terrorist attack on the Pentagon and the anthrax letters, and at the direction of the Governor of Texas, as part of our Texas State Guard and Militia Volunteer Unit, I now command a new volunteer unit we are forming, the Texas Medical Rangers, which is in response to President Bush's call for a medical reserve corps.

We will establish elements of this on each of our eight health science campuses around the state and grow to a unit of over 2,000 professionals—doctors, nurses, dentists, allied health, all ranges of professional health care teams—to respond to our Governor's need to respond across the state in case of emergencies or disasters.

The federal assets in the military, including its reserves and the VA, commissioned corps of the U.S. Public Health Service really represent the largest group of trained, mobile, reassignable health professionals in the country, and likewise, at the state level, we must recognize the tremendous potential of academic health centers—our nation's medical schools—in contributing public health preparedness as a component of clinical surge capacity.

Your law establishing the Veterans' Affairs Emergency Preparedness Act envision several medical emergency preparedness centers. You're well aware of the missions of this. It's a well-conceived law.

We, with our unique environment in San Antonio and South Texas are ideally situated to fulfill all of those missions with excellence and to have additional benefits in terms of adding to scientific knowledge in the areas of environmental and toxic exposures, which this last panel just addressed, an area of expertise which we really have developed in San Antonio at Brooks City Base, with the Air Force and some of our other biotech industry, as well as on our university campus.

In addition, our research teams have access to one of the nation's few BSL4 laboratories, which is at the Southwest Foundation for Biomedical Research. We're actively engaged in a promising new oral smallpox vaccine. We're doing research with DARPA on an enhancement to the anthrax vaccine.

We have research ongoing in plague, tularemia, and pox viruses, so you can see—and in conjunction with our medical branch in Galveston, who is about to open a very large BSL4, we're really going to be part of a regional center of excellence and well prepared to do the mission of this law that you have well crafted.

San Antonio is the home of military medicine, a large active duty population, a retired military, veteran population, and it's natural for a community with our federal and state assets and the population we serve to be involved in the continuum of clinical care and the research that needs to come out of that to solve these problems that have been well described in the Gulf illness over the last 12 years.

We're not there yet. There's a lot more research that needs to be ongoing, and particularly as the human genome really opens up additional scientific areas of inquiry, I think that's where we're going to find many of these answers to the veterans' and other problems.

Mr. SIMMONS. Thank you, doctor. As the light glows yellow and then it goes red, unfortunately, it means summarize as quickly as you can.

Dr. TIMBOE. All right, sir.

Well, San Antonio, again, you know my enthusiasm. I've spent time in Washington.

Mr. SIMMONS. Of course.

Dr. TIMBOE. And really, the border area, with its health disparities, its very special environmental exposures, I think it's right for a whole group of federal agencies to locate there as a regional center and on a campus that can provide synergy for all of them to communicate and work together.

Again, thank you, sir, for the opportunity to be here and express our support for this well-crafted law.

[The prepared statement of Dr. Timboe appears on p. 151.]

Mr. SIMMONS. Thank you. Now, Dr. Terndrup.

STATEMENT OF THOMAS E. TERNDRUP

Dr. TERNDRUP. Thank you, Chairman Simmons and members of the committee. Good afternoon.

Mr. SIMMONS. Good afternoon.

Dr. TERNDRUP. My name is Tom Terndrup. I am Professor and Chair of the Department of Emergency Medicine at the University of Alabama at Birmingham. I'm also the Director of the Center for Disaster Preparedness at UAB.

We appreciate the opportunity to be here today and speak on behalf of Dean William Deal of the UA School of Medicine.

I'm here to speak in support of Public Law 107–287. Funding, specifically funding for the establishment of four VA Centers of Excellence should, in my opinion, be established with utmost speed, as many of the speakers have indicated this morning, to ensure that our so on-to-be-future veterans and our citizens can be afforded the security improvements that those centers, I believe, would bring to bear immediately.

I'm a career emergency physician. I have treated thousands of victims of seemingly routine, small-scale disaster incidents, such as those that occur on our nation's highways and in our communities on a daily basis.

I'm also an educator, and I've educated nurses, doctors, and other staff members in the necessary recognition and treatment of a wide array of these emergency disorders. I train people to save lives.

However, none of these has been as challenging, as important as the tasks, I think, at present. That is, preparing our nation's health care delivery system and its personnel for responding to the consequences of WMD.

In this effort, the vital relationships between VA medical centers and our academic health centers is key, and I think our universities should be tapped in order for our nation to be better prepared.

Secretary Tommy Thompson has said, "Knowledge is the health care system's greatest weapon" against terrorism. I believe that's true, and I believe that academic health centers collaborating with VA are important national assets, and those relationships can be exploited to improve our nation's counterterrorism efforts.

At UAB, we formed the Center for Disaster Preparedness in 1999 in order to address issues associated with preparation for biological terrorist attacks and other disasters through broad-based, multidisciplinary research, training, and service programs. Our local Birmingham VA personnel were instrumental in the formation of that center.

The center's goal is to provide a formal structure to facilitate collaborative efforts between experts from a wide range of disciplines in order to address the many issues surrounding disaster preparedness.

Our experts in public health, drug delivery, medical operations, rare and emerging infections, and basic and clinical research, we work together to strengthen our nation's biological shield.

These individuals work collaboratively in improving awareness and preparation for professions for possible weapons of mass de-

struction incidents. We've built strong relationships with other universities in the United States, as well, including Louisiana State and Vanderbilt Universities, who, together with UAB, form the National Health Professions Preparedness Consortium.

UAB is also collaborating with other southeastern universities in responding to NIH's call for regional centers of excellence in biodefense research. I'm intimately familiar with the broad capabilities that such multidisciplinary centers can bring to bear on this problem we have.

Our collaborative disaster center training activities include the nation's only live-exercise WMD course which achieves health care leadership integration in responding to WMD incidents. We achieve this through utilization and modification of Homeland Security's Noble Training Center in Anniston, AL. Our local Birmingham VA has also been a key component of the design and implementation of these training missions.

The VA's National Disaster Medical System and our local DMAT team, our Disaster Medical Assistance Team, have actively collaborated, and recently were deployed to the World Trade Center attacks. The planning, coordination, and training activities have included conferences on post-deployment health and evaluation and optimization of that health, an essential in our post-"Iraqi Freedom" world.

The University of Alabama School of Medicine is one of the nation's top medical schools, with education, research and patient care missions. It's ranked in the upper echelon of federally funded medical schools for over two decades.

Our faculty responded to various threats, including that of HIV/AIDS, ongoing problems such as arthritis, heart disease, organ transplantation, cancer, and now we're directing those to anthrax and other risk agents.

Disaster preparedness is another example of our eagerness to serve the nation and the world.

Our public law that we've been discussing today establishes emergency preparedness centers at VA which have strong collaborations with qualifying medical and public health schools, as well as other appropriate research and educational activities.

The mission of VA has been well described here, but it includes that of education and research, very important for the mission today.

A local example pointed out at the Birmingham VA is we have initiated a project to evaluate better ways of training physicians and nurses to detect patients who are victims of bioterrorist attacks.

This project utilizes the advanced VA computer capabilities to provide training, and it leverages a project supported by the Agency for Health Care Research the Quality that we are continuing to work on at the Center for Disaster Preparedness. This project will inform us not only about training VA personnel, but also training community based health care providers nationwide.

Last year, we trained a VA Quality Scholar, Dr. Jessica Jones, in bioterrorism, with many collaborators, including Drs. Catarina Kiefe and Norm Weissman, who I collaborate with in bioterrorism

preparedness. Now, she's acting in Los Angeles County as the assistant director for bioterrorism preparedness.

Public Law 107–287, in my view, creates a joint program between Department of Veterans Affairs and Department of Defense in which a series of model education and training programs on the medical response to the consequences of terrorist activities are developed and disseminated.

I agree with my other panelists here. The long history of the collaboration that exists between VA and academic centers and medical schools really needs to be leveraged as we consider these problems.

In closing, let me point out that existing resources should not be reassigned for this proposal. Rather, additional resources should be added to this specific program. I haven't heard any debate about that in the negative that morning.

These resources should be instrumental in securing our homeland, and they will build upon existing strengths of the existing VA and academic health centers and their relationships.

Thank you.

[The prepared statement of Dr. Terndrup appears on p. 154.]

Mr. SIMMONS. Thank you, doctor.

I have some questions for the panel, but my colleague is under a time constraint, so I will defer to him, and then ask my questions.

Mr. RODRIGUEZ. Thank you, Mr. Chairman.

I want to thank the entire panel, first of all, for coming, and Dr. Timboe, thank you very much for being here.

Let me ask you, I know you talked about the Texas Medical Rangers, and we were looking at the numbers, even just from the VA perspective, of the amount that they've already expended since 9/11. For one year, I think it was estimated at 55 million and then expected 60-something million when it deals with training, technology, maybe even different infrastructure needs when we look at preparing.

I was wondering, if you had your 'druthers, you know, what kind of budget do you foresee that might be needed when you look at the Texas Medical Rangers and/or the type of budgets that we're looking at for now for the response centers and the type of areas that we need to concentrate on?

Dr. TIMBOE. Well, thank you, sir. I think, in responding to and being prepared, you need plans, you need people, you need products, equipment, supplies for them to work with, and you need them to practice exercises, and then reassess where they are.

We're going to get our people virtually for free. We need some people really full-time, half-time to do planning, exercise designs, to help coordinate the volunteer activities, and so you need several full-time people essentially at each campus.

You need probably a modicum of communications capabilities, and a small amount of equipment, because you're really going to be using the local community's equipment which you come into and augment there.

So it's a relatively small amount of money that you can leverage a lot of subject matter expertise.

We have, I would say, in the range of about $1 million per campus would really get you a good leverage point on building preparedness.

Mr. RODRIGUEZ. Okay. Let me once again thank you and also indicate to you that when we testify, we also only get 5 minutes. Okay? And sometimes even just 1 minute on the House floor.

Thank you.

Mr. SIMMONS. I have several questions that I want to ask of each of you. Why don't I just ask them, and then you can respond as you see fit.

First question. If your university was designated as a Veterans Administration Bioterrorism Research Center, how prepared are you to accept that designation should it come? I mean, is this something that you could say, "Wow, we'll be ready in 48 hours," or is this something that's going to involve 6 months to a year of planning? That's Point 1.

Point 2. What mechanisms are in place, if any, to disseminate bioresearch findings to national health care providers?

In my own involvement with the University of Connecticut, we do some extraordinary things at a theoretical level, but when it comes to applied research, sometimes it's like, "Well, you know, what do you mean we've got to share it with the world for some practical purpose?"

Thirdly, I think, Dr. Timboe, you mentioned participating in some training exercises.

Have any of the panelists or their universities participated in a simulated bioterrorism exercise, a catastrophic exercise of one sort or another?

Mr. FELDMAN. I'll start on some of these.

I think that the answer to how ready are we to implement such a center is going to be different from one site to another, but I think that in general the medical schools and the VA systems have established already pretty good lines of communication and collaboration on a variety of programs, and at our facility, we have many faculty who have joint appointments between the VA and the medical school, so their salaries are shared and they rotate between the sites of the main medical center as well as the VA facility.

We have many collaborative research programs looking at Gulf War Syndrome, looking at chronic fatigue syndrome, which is showing up more in veterans, that we do at both sites with common faculty; so I think the lead time is not great to start up this kind of a program

I was particularly interested in your question about sharing information with a practicing physician. Let me just give you an example of some of the things that we do.

First off, we've already integrated ourselves into the homeland preparedness activities of the Health Department of the State of New Jersey, and by that mechanism, we're working with physicians, practicing physicians at the county level, to share information and procedures on how to deal with emergencies.

But the other thing that we do is we work very closely with the Medical Society of the State of New Jersey and we provide ongoing continuing education programs in the hospitals, and the program that has been most active in the last year-and-a-half, which I par-

ticipate in, is related to bioterrorism and particularly to infectious diseases.

So the expertise of our Center for Emerging Pathogens is directly translated to practicing physicians, and I'm sure that other universities are doing similar type things.

The jumpstart that this kind of a bill could provide to really put this in a high gear, which I believe is going to be needed if a threat emerges, is so obvious to most of us that it's really hard to beat on Congress for this. I think you're already on board in most instances, and it's the matter of getting the money appropriated.

Mr. SIMMONS. You're absolutely correct, it's a matter of getting the money appropriated. Thank you for that comment.

Dr. TIMBOE. Sir, let me just add to that, as our titles imply, we already have an ongoing effort at many academic health centers and medical schools that are trying to organize the work of the universities in education, research, training, community planning, but we've taken it out of hide, and in some respects we're kind of doing it—we're working on, you know, one-and-a-half cylinders, when we really like to be going on all eight cylinders in helping move our communities and regions forward.

I think a little bit of—we could rapidly ramp up to a full coordinated effort and integrating with the VA's assets. A little bit depends on what the VA Central Office wants us to do at the four centers relative VISN-wide, multi-VISN, how to ensure that we can fulfill the rest of their mission for the education effort, infrastructure protection, building decontamination capabilities, the pharmaceutical caches that they want to put out there, and would these centers have a role as regional coordination centers broadly across the 50 states.

You could ask the question is four enough, then? Would you might want to go to six or eight or 10 in that broader context?

We already have a lot of research going on. We could fully consume these $20 million in additional research, well conceived, but NIH has a lot of that money, too, and we're going to compete for that and do more research in that effort.

We have been doing a citywide smallpox exercise, we did a citywide anthrax exercise, plague, and we're about to do a radiological dirty bomb type scenario.

We've received the national pharmaceutical stockpile at least once. We got another coming, to see how we can get that out quickly into our community centers.

So we're engaged, but we can really use the help to not do it on a shoestring.

Mr. SIMMONS. Just as a point of comment, I'd be interested in any followup on our smallpox exercise, if you could give us an after-action report on that. Is that going to come anytime soon?

Dr. TIMBOE. Yes, I sure can.

(The information follows:)

AMEDDEX 2002

Homeland Security Symposium and Exercise
Sponsored by the AMEDD Center and School

LTC Joanne E. McGovern
Chief, Homeland Security Branch

"While the threat of a smallpox attack is believed to be low, it is indeed possible, and unfortunately, we now live in a world where we need to be prepared ... "

Secretary Tommy Thompson
Department of Health and Human Services

The Event

Pale Horse was a five -day event that promoted interaction between the civil, military, public, and private sect or.

Conducted in three phases:

- Symposium
- Functional Exercise
- Executive Seminar

Purpose

- To educate
- To examine the challenges
- To capture lessons learned and identify unresolved issues

Goals and Objectives

- Foster critical thinking
- Identify roles and responsibilities
- Exercise existing plans
- Identify shortfalls,Issues and recommend possible solutions

Four Hundred And Seventy Five Participants

The Exercise

The Scenario

The scenario depicted the activities and events associated with a bioterrorism attack on the city of San Antonio, Texas.

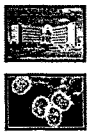
Two patients presenting at local emergency rooms with flu like symptoms and are treated symptomatically. The patients return in two days and both are dramatically ill.

Note: The After Action Review (AAR) is not yet complete, but this set of slides is from a recent presentation by the Pale House Exercise Organizer and should be informative.

The Exercise

The Scenario

Staff at both hospitals immediately susp ect an infectious illness and initiate clinical tests to identify the cause of the illness and reluctantly begin to consider the possibility that they mig ht be dealing with the first cases of smallpox to be seen in the world since 1978.



The Exercise

The Scenario

Thus begins the story of one American city's battle to contain an outbreak of smallpox.

What We Learned

Command and Control

- ✓ Organizations that used some form of the Incident Command System (ICS) or the H ospital Emergency Incid ent Command System (HEICS) were able to res pond quicker and more effectively
- ✓ Public health rec ognized as a key leadershi p segment
- ✓ The intensity of event forced broader communication among agencies and more risk taking
- ✓ Public information critical
- ✓ Information processing - overwhelming

What We Learned

Medical Operation Center

- ✓ Medical Operati ons Center Concept WORKS!!!!
- ✓ Availability of subject matter exp erts
- ✓ Integration of public, private, and military expertise
- ✓ Timely informa tion transfer among EOC, MOC, and PH
- ✓ Role/respo nsibility definition be tween agencies
- ✓ Availability of canned/sta ndardized templates and forms

What We Learned

Public Health

- ✓ Immunization
  - Prioritization – Who gets shot first
  - Timeliness – How long does it take to get once the decision is made to release the stock
  - Distribution
  - Storage
  - Security
  - IND
    - Protocols severely impacts how quickly the population can be immunized
    - Paper work/interviews – Manpower (3:1 ratio) intensive and requires education and training
  - Manpower Intensive
  - Requires Training
  - Volunteer Medical Work Corps
  - Impacts on Work Force
  - Lack of VIG
  - Civilian policy differences; perceived inequalities

Bottom Line: MUST Immunize First Responders and Hospital Personnel Prior to an Attack

What We Learned

Public Health

- ✓ Quarantine and mass casu alty disposition
  - Must be integrated into the plans
  - Laws, Policy, proce dures in place
  - Identification of facilities
- ✓ Recognition of importance epidemiology
  - Epi investigation must be initiated immediately
  - Timeliness is critical
  - Tied to criminal investig ation
  - Linked to GIS

What We Learned
Public Health

- ✓ "Depth" in public health staffing
- ✓ Communication with federal entities
- ✓ Need for medical reserve corps (volunteer corps)

What We Learned
Psychological Impact

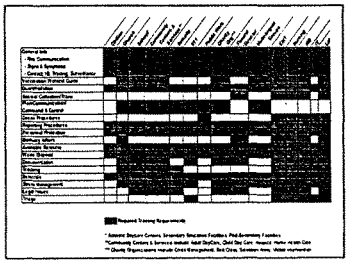
- ✓ Pre-event organization and integration of community resiliency
- ✓ Multi-media delivery of positive, emotional, psychological, pastoral messages to entire community
- ✓ Coordination of human services
- ✓ Perceived threat versus reality

What We Learned
Mass Care

- ✓ Clinical practice guidelines to manage smallpox scenario
- ✓ Definitive plan for full spectrum of care and possible isolation of smallpox patients
- ✓ support and possible isolation of immunocompromised individuals
- ✓ Definitive immunization plan
- ✓ Definitive distribution and logistic plan
- ✓ Plan to identify clean/dirty hospitals or alternative treatment areas

What We Learned
Training

- ✓ Focus of training—audience, level, content
- ✓ Pre-event education critical for success
- ✓ "Just in Time" training will be required
- ✓ Train the trainer during a crisis the best approach "pyramid"
- ✓ Delivery of training– redundant, high tech/low tech
  - Multiple mediums
  - Internet
  - Television
  - Radio
  - Press
  - FAX
  - Mass Mailings
  - Multilingual



What We Learned
Information Operations/Risk Communication

- ✓ Redundant, high capacity, secure communication
- ✓ Appeal to public to minimize communications
- ✓ Standardized data elements and collection
- ✓ Centralized public information on one website linked from all agency sites

What We Learned
Utilities and Logistics

- ✓ "We will not be doing business as usual"
- ✓ Logistics management—internal and external
- ✓ Just In Time" supply mechanism fraught with pitfalls
- ✓ Human resource impacts will limit services and support
- ✓ Industries other than health have mission critical employees
- ✓ Local Emergency Planning Committees (LEPC) are resource for bakers and candlestick makers prior to event (planning)

What We Learned
Fatality Management

- ✓ Retrieval
- ✓ Disposition
- ✓ Notification/family assistance
- ✓ Variability in Medical Examiner authority/responsibility in other states/jurisdictions

What We Learned
Legal

- ✓ Awareness of constitutional right of privacy, due process for deprivations of liberty, takings, and Presidential powers
- ✓ Analysis of power limits: state public health on control measures, vaccination, human remains, and the Governor's emergency powers
- ✓ Understanding of different levels of control to achieve order, including deadly force
- ✓ Liability for private health care providers and governments for professional services and governmental responsibilities, respectively

Issues

- ✓ Vaccination (see slide)
- ✓ "Relationship between medical and law enforcement
- ✓ Transnational issue, especially where there is little treatment capability, a migrant population, and the disease is traceable to a U.S. incident
- ✓ Plan for succession in the event leaders are not present
- ✓ Requirements vs organizations vs capability
- ✓ Funding/financial issues not understood
  - ✓ Disaster vs National Emergency
  - ✓ DoD vs Civilian
  - ✓ Economic impacts – small businesses, bee closures, ATM's
- ✓ Logistics
  - ✓ Food
  - ✓ Medication
  - ✓ Fuel
  - ✓ Infrastructure
  - ✓ Basic needs and services

Mr. SIMMONS. We've just been called for a 15-minute vote. Dr. Terndrup, I'd like your response.

I'd also like to suggest to each of the panelists that, since the appropriations process is the problem here, that a certain Mr. Aderholt, a certain Mr. Bonilla, and a certain Mr. Frelinghuysen all serve on the Appropriations Committee. Drop by and visit them before you go home today.

Dr. TERNDRUP. Duly noted, Chairman Simmons.

Mr. SIMMONS. We have about 5 minutes before I'm going to have to leave and conclude the hearing, so please, Dr. Terndrup.

Dr. TERNDRUP. Thank you, Chairman Simmons.

I would add my comments as well to your three questions.

We're ready to go. We started on a shoestring. We continue to operate on some shoestrings. Infrastructure support would be extraordinarily valuable in stabilizing our existing activities and helping us to link even stronger to our VA Medical Center in the Birmingham region in VISN 7, so we're ready to go whenever you want to send the money.

Disseminating the findings to providers is something that we do every day. We have a web site that is www.bioterrorism.uab.edu. That web site is available 24 hours a day, and shortly will become a .gov web site.

We have issued about 1,500 continuing medical education certificates to health care providers since opening up the web site, and that serves as a fundamentally important part of how we reach out, as well as other mechanisms of continuing education to the physician and other health care provider community.

We regularly involve ourselves in training exercise, in training other hospital providers who are often left out of the training loop otherwise, through training at the Noble Training Center in Anniston.

What happened there, Mr. Simmons, was that the old Fort McClellan hospital, Noble Army hospital, as the base was closed down, that was converted into a training center, using assets from the Department of Health and Human Services.

That training center brings in approximately 50 Americans every other week for a 4-day training exercise. It's the only live training exercise that intends to focus on the health care leadership that would be involved in responding to any significant incident, such as a smallpox attack or an anthrax attack, and the like.

So we actually are doing a number of things to participate in the education of physicians and the other health care providers that we think we need to address.

Mr. SIMMONS. Thank you very much.

I notice that we've been joined by my distinguished colleague from New Hampshire, Mr. Bradley. Do you have any questions or comments you'd like to make?

Mr. BRADLEY. No, thank you.

Mr. SIMMONS. Thanks for being here.

Members of the panel and those who are still with us here today, thank you for your participation. The issues that have been raised are serious ones.

My colleague has suggested that members of this committee might wish to address this issue in the context of the urgent sup-

plemental, which I understand will be up next week. That may come to pass. I certainly hope it does.

But for myself, I am also prepared to introduce legislation to overturn the prohibition that was laid out by the Appropriations Committee, if we're not able to take advantage of the urgent supplemental next week.

These are important issues. I've always felt that Americans are terrific when it comes to reacting to problems. We're not so good sometimes when it comes to proactive approaches, but this is a classic case where we have to be prepared, because failure to be prepared is going to cost perhaps many thousands of lives, maybe more.

Thank you for your testimony. Thanks to the staff for setting up this subcommittee hearing, and this hearing is concluded.

[Whereupon, at 12:45 p.m., the subcommittee was adjourned.]

APPENDIX

PUBLIC LAW 107–287—NOV. 7, 2002

DEPARTMENT OF VETERANS AFFAIRS EMERGENCY PREPAREDNESS ACT OF 2002

Public Law 107–287
107th Congress

An Act

Nov. 7, 2002
[H.R. 3253]

To amend title 38, United States Code, to enhance emergency preparedness of the Department of Veterans Affairs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Department of Veterans Affairs Emergency Preparedness Act of 2002.
38 USC 101 note.

SECTION 1. SHORT TITLE.

This Act may be cited as the "Department of Veterans Affairs Emergency Preparedness Act of 2002".

SEC. 2. ESTABLISHMENT OF MEDICAL EMERGENCY PREPAREDNESS CENTERS AT DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTERS.

(a) IN GENERAL.—(1) Subchapter II of chapter 73 of title 38, United States Code, is amended by adding at the end the following new section:

"§ 7325. Medical emergency preparedness centers

"(a) ESTABLISHMENT OF CENTERS.—(1) The Secretary shall establish four medical emergency preparedness centers in accordance with this section. Each such center shall be established at a Department medical center and shall be staffed by Department employees.

"(2) The Under Secretary for Health shall be responsible for supervising the operation of the centers established under this section. The Under Secretary shall provide for ongoing evaluation of the centers and their compliance with the requirements of this section.

"(3) The Under Secretary shall carry out the Under Secretary's functions under paragraph (2) in consultation with the Assistant Secretary of Veterans Affairs with responsibility for operations, preparedness, security, and law enforcement functions.

"(b) MISSION.—The mission of the centers shall be as follows:

"(1) To carry out research on, and to develop methods of detection, diagnosis, prevention, and treatment of injuries, diseases, and illnesses arising from the use of chemical, biological, radiological, incendiary or other explosive weapons or devices posing threats to the public health and safety.

"(2) To provide education, training, and advice to health care professionals, including health care professionals outside the Veterans Health Administration, through the National Disaster Medical System established pursuant to section 2811(b) of the Public Health Service Act (42 U.S.C. 300hh–11(b)) or through interagency agreements entered into by the Secretary for that purpose.

"(3) In the event of a disaster or emergency referred to in section 1785(b) of this title, to provide such laboratory, epidemiological, medical, or other assistance as the Secretary considers appropriate to Federal, State, and local health care agencies and personnel involved in or responding to the disaster or emergency.

"(c) SELECTION OF CENTERS.—(1) The Secretary shall select the sites for the centers on the basis of a competitive selection process. The Secretary may not designate a site as a location for a center under this section unless the Secretary makes a finding under paragraph (2) with respect to the proposal for the designation of such site. To the maximum extent practicable, the Secretary shall ensure the geographic dispersal of the sites throughout the United States. Any such center may be a consortium of efforts of more than one medical center.

"(2) A finding by the Secretary referred to in paragraph (1) with respect to a proposal for designation of a site as a location of a center under this section is a finding by the Secretary, upon the recommendations of the Under Secretary for Health and the Assistant Secretary with responsibility for operations, preparedness, security, and law enforcement functions, that the facility or facilities submitting the proposal have developed (or may reasonably be anticipated to develop) each of the following:

"(A) An arrangement with a qualifying medical school and a qualifying school of public health (or a consortium of such schools) under which physicians and other persons in the health field receive education and training through the participating Department medical facilities so as to provide those persons with training in the detection, diagnosis, prevention, and treatment of injuries, diseases, and illnesses induced by exposures to chemical and biological substances, radiation, and incendiary or other explosive weapons or devices.

"(B) An arrangement with a graduate school specializing in epidemiology under which students receive education and training in epidemiology through the participating Department facilities so as to provide such students with training in the epidemiology of contagious and infectious diseases and chemical and radiation poisoning in an exposed population.

"(C) An arrangement under which nursing, social work, counseling, or allied health personnel and students receive training and education in recognizing and caring for conditions associated with exposures to toxins through the participating Department facilities.

"(D) The ability to attract scientists who have made significant contributions to the development of innovative approaches to the detection, diagnosis, prevention, or treatment of injuries, diseases, and illnesses arising from the use of chemical, biological, radiological, incendiary or other explosive weapons or devices posing threats to the public health and safety.

"(3) For purposes of paragraph (2)(A)—

"(A) a qualifying medical school is an accredited medical school that provides education and training in toxicology and environmental health hazards and with which one or more of the participating Department medical centers is affiliated; and

"(B) a qualifying school of public health is an accredited school of public health that provides education and training

in toxicology and environmental health hazards and with which one or more of the participating Department medical centers is affiliated.

"(d) RESEARCH ACTIVITIES.—Each center shall conduct research on improved medical preparedness to protect the Nation from threats in the area of that center's expertise. Each center may seek research funds from public and private sources for such purpose.

"(e) DISSEMINATION OF RESEARCH PRODUCTS.—(1) The Under Secretary for Health and the Assistant Secretary with responsibility for operations, preparedness, security, and law enforcement functions shall ensure that information produced by the research, education and training, and clinical activities of centers established under this section is made available, as appropriate, to healthcare providers in the United States. Dissemination of such information shall be made through publications, through programs of continuing medical and related education provided through regional medical education centers under subchapter VI of chapter 74 of this title, and through other means. Such programs of continuing medical education shall receive priority in the award of funding.

"(2) The Secretary shall ensure that the work of the centers is conducted in close coordination with other Federal departments and agencies and that research products or other information of the centers shall be coordinated and shared with other Federal departments and agencies.

"(f) COORDINATION OF ACTIVITIES.—The Secretary shall take appropriate actions to ensure that the work of each center is carried out—

"(1) in close coordination with the Department of Defense, the Department of Health and Human Services, and other departments, agencies, and elements of the Government charged with coordination of plans for United States homeland security; and

"(2) after taking into consideration applicable recommendations of the working group on the prevention, preparedness, and response to bioterrorism and other public health emergencies established under section 319F(a) of the Public Health Service Act (42 U.S.C. 247d–6(a)) or any other joint interagency advisory group or committee designated by the President or the President's designee to coordinate Federal research on weapons of mass destruction.

"(g) ASSISTANCE TO OTHER AGENCIES.—The Secretary may provide assistance requested by appropriate Federal, State, and local civil and criminal authorities in investigations, inquiries, and data analyses as necessary to protect the public safety and prevent or obviate biological, chemical, or radiological threats.

"(h) DETAIL OF EMPLOYEES FROM OTHER AGENCIES.—Upon approval by the Secretary, the Director of a center may request the temporary assignment or detail to the center, on a nonreimbursable basis, of employees from other departments and agencies of the United States who have expertise that would further the mission of the center. Any such employee may be so assigned or detailed on a nonreimbursable basis pursuant to such a request.

"(i) FUNDING.—(1) Amounts appropriated for the activities of the centers under this section shall be appropriated separately from amounts appropriated for the Department for medical care.

"(2) In addition to funds appropriated for a fiscal year specifically for the activities of the centers pursuant to paragraph (1), the Under Secretary for Health shall allocate to such centers from other funds appropriated for that fiscal year generally for the Department medical care account and the Department medical and prosthetics research account such amounts as the Under Secretary determines appropriate to carry out the purposes of this section. Any determination by the Under Secretary under the preceding sentence shall be made in consultation with the Assistant Secretary with responsibility for operations, preparedness, security, and law enforcement functions.

"(3) There are authorized to be appropriated for the centers under this section $20,000,000 for each of fiscal years 2003 through 2007.".

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 7324 the following new item:

"7325. Medical emergency preparedness centers.".

Establishment. 38 USC 7325 note.

(b) PEER REVIEW FOR DESIGNATION OF CENTERS.—(1) In order to assist the Secretary of Veterans Affairs and the Under Secretary of Veterans Affairs for Health in selecting sites for centers under section 7325 of title 38, United States Code, as added by subsection (a), the Under Secretary shall establish a peer review panel to assess the scientific and clinical merit of proposals that are submitted to the Secretary for the designation of such centers. The peer review panel shall be established in consultation with the Assistant Secretary of Veterans Affairs with responsibility for operations, preparedness, security, and law enforcement functions.

(2) The peer review panel shall include experts in the fields of toxicological research, infectious diseases, radiology, clinical care of patients exposed to such hazards, and other persons as determined appropriate by the Secretary. Members of the panel shall serve as consultants to the Department of Veterans Affairs.

(3) The panel shall review each proposal submitted to the panel by the officials referred to in paragraph (1) and shall submit to the Under Secretary for Health its views on the relative scientific and clinical merit of each such proposal. The panel shall specifically determine with respect to each such proposal whether that proposal is among those proposals which have met the highest competitive standards of scientific and clinical merit.

(4) The panel shall not be subject to the Federal Advisory Committee Act (5 U.S.C. App.).

SEC. 3. EDUCATION AND TRAINING PROGRAMS ON MEDICAL RESPONSES TO CONSEQUENCES OF TERRORIST ACTIVITIES.

(a) IN GENERAL.—(1) Subchapter II of chapter 73 of title 38, United States Code, is amended by adding after section 7325, as added by section 2(a)(1), the following new section:

"§ 7326. Education and training programs on medical response to consequences of terrorist activities

"(a) EDUCATION PROGRAM.—The Secretary shall carry out a program to develop and disseminate a series of model education and training programs on the medical responses to the consequences of terrorist activities.

"(b) IMPLEMENTING OFFICIAL.—The program shall be carried out through the Under Secretary for Health, in consultation with the Assistant Secretary of Veterans Affairs with responsibility for operations, preparedness, security, and law enforcement functions.

"(c) CONTENT OF PROGRAMS.—The education and training programs developed under the program shall be modelled after programs established at the F. Edward Hebért School of Medicine of the Uniformed Services University of the Health Sciences and shall include, at a minimum, training for health care professionals in the following:

"(1) Recognition of chemical, biological, radiological, incendiary, or other explosive agents, weapons, or devices that may be used in terrorist activities.

"(2) Identification of the potential symptoms of exposure to those agents.

"(3) Understanding of the potential long-term health consequences, including psychological effects, resulting from exposure to those agents, weapons, or devices.

"(4) Emergency treatment for exposure to those agents, weapons, or devices.

"(5) An appropriate course of followup treatment, supportive care, and referral.

"(6) Actions that can be taken while providing care for exposure to those agents, weapons, or devices to protect against contamination, injury, or other hazards from such exposure.

"(7) Information on how to seek consultative support and to report suspected or actual use of those agents.

"(d) POTENTIAL TRAINEES.—In designing the education and training programs under this section, the Secretary shall ensure that different programs are designed for health-care professionals in Department medical centers. The programs shall be designed to be disseminated to health professions students, graduate health and medical education trainees, and health practitioners in a variety of fields.

"(e) CONSULTATION.—In establishing education and training programs under this section, the Secretary shall consult with appropriate representatives of accrediting, certifying, and coordinating organizations in the field of health professions education.".

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 7325, as added by section 2(a)(2), the following new item:

"7326. Education and training programs on medical response to consequences of terrorist activities.".

38 USC 7326 note.

(b) EFFECTIVE DATE.—The Secretary of Veterans Affairs shall implement section 7326 of title 38, United States Code, as added by subsection (a), not later than the end of the 90-day period beginning on the date of the enactment of this Act.

SEC. 4. AUTHORITY TO FURNISH HEALTH CARE DURING MAJOR DISASTERS AND MEDICAL EMERGENCIES.

(a) IN GENERAL.—(1) Subchapter VIII of chapter 17 of title 38, United States Code, is amended by adding at the end the following new section:

"§ 1785. Care and services during certain disasters and emergencies

"(a) AUTHORITY TO PROVIDE HOSPITAL CARE AND MEDICAL SERVICES.—During and immediately following a disaster or emergency referred to in subsection (b), the Secretary may furnish hospital care and medical services to individuals responding to, involved in, or otherwise affected by that disaster or emergency.

"(b) COVERED DISASTERS AND EMERGENCIES.—A disaster or emergency referred to in this subsection is any disaster or emergency as follows:

"(1) A major disaster or emergency declared by the President under the Robert B. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5121 et seq.).

"(2) A disaster or emergency in which the National Disaster Medical System established pursuant to section 2811(b) of the Public Health Service Act (42 U.S.C. 300hh–11(b)) is activated by the Secretary of Health and Human Services under paragraph (3)(A) of that section or as otherwise authorized by law.

"(c) APPLICABILITY TO ELIGIBLE INDIVIDUALS WHO ARE VETERANS.—The Secretary may furnish care and services under this section to an individual described in subsection (a) who is a veteran without regard to whether that individual is enrolled in the system of patient enrollment under section 1705 of this title.

"(d) REIMBURSEMENT FROM OTHER FEDERAL DEPARTMENTS AND AGENCIES.—(1) The cost of any care or services furnished under this section to an officer or employee of a department or agency of the United States other than the Department or to a member of the Armed Forces shall be reimbursed at such rates as may be agreed upon by the Secretary and the head of such department or agency or the Secretary concerned, in the case of a member of the Armed Forces, based on the cost of the care or service furnished.

"(2) Amounts received by the Department under this subsection shall be credited to the Medical Care Collections Fund under section 1729A of this title.

"(e) REPORT TO CONGRESSIONAL COMMITTEES.—Within 60 days of the commencement of a disaster or emergency referred to in subsection (b) in which the Secretary furnishes care and services under this section (or as soon thereafter as is practicable), the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on the Secretary's allocation of facilities and personnel in order to furnish such care and services. Deadline.

"(f) REGULATIONS.—The Secretary shall prescribe regulations governing the exercise of the authority of the Secretary under this section.".

(2) The table of sections at the beginning of that chapter is amended by adding at the end the following new item:

"1785. Care and services during certain disasters and emergencies.".

(b) MEMBERS OF THE ARMED FORCES ON ACTIVE DUTY.—Section 8111A(a) of such title is amended—

(1) by redesignating paragraph (2) as paragraph (4);

(2) by designating the second sentence of paragraph (1) as paragraph (3); and

(3) by inserting between paragraph (1) and paragraph (3), as designated by paragraph (2) of this subsection, the following new paragraph:

"(2)(A) During and immediately following a disaster or emergency referred to in subparagraph (B), the Secretary may furnish hospital care and medical services to members of the Armed Forces on active duty responding to or involved in that disaster or emergency.

"(B) A disaster or emergency referred to in this subparagraph is any disaster or emergency as follows:

"(i) A major disaster or emergency declared by the President under the Robert B. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5121 et seq.).

"(ii) A disaster or emergency in which the National Disaster Medical System established pursuant to section 2811(b) of the Public Health Service Act (42 U.S.C. 300hh–11(b)) is activated by the Secretary of Health and Human Services under paragraph (3)(A) of that section or as otherwise authorized by law.".

SEC. 5. INCREASE IN NUMBER OF ASSISTANT SECRETARIES OF VETERANS AFFAIRS.

(a) INCREASE.—Subsection (a) of section 308 of title 38, United States Code, is amended by striking "six" in the first sentence and inserting "seven".

(b) FUNCTIONS.—Subsection (b) of such section is amended by adding at the end the following new paragraph:

"(11) Operations, preparedness, security, and law enforcement functions.".

(c) NUMBER OF DEPUTY ASSISTANT SECRETARIES.—Subsection (d)(1) of such section is amended by striking "18" and inserting "19".

(d) CONFORMING AMENDMENT.—Section 5315 of title 5, United States Code, is amended by striking "(6)" after "Assistant Secretaries, Department of Veterans Affairs" and inserting "(7)".

SEC. 6. CODIFICATION OF DUTIES OF SECRETARY OF VETERANS AFFAIRS RELATING TO EMERGENCY PREPAREDNESS.

(a) IN GENERAL.—(1) Subchapter I of chapter 81 of title 38, United States Code, is amended by adding at the end the following new section:

"§ 8117. Emergency preparedness

"(a) READINESS OF DEPARTMENT MEDICAL CENTERS.—(1) The Secretary shall take appropriate actions to provide for the readiness of Department medical centers to protect the patients and staff of such centers from chemical or biological attack or otherwise to respond to such an attack so as to enable such centers to fulfill their obligations as part of the Federal response to public health emergencies.

"(2) Actions under paragraph (1) shall include—

"(A) the provision of decontamination equipment and personal protection equipment at Department medical centers; and

"(B) the provision of training in the use of such equipment to staff of such centers.

"(b) SECURITY AT DEPARTMENT MEDICAL AND RESEARCH FACILITIES.—(1) The Secretary shall take appropriate actions to provide

for the security of Department medical centers and research facilities, including staff and patients at such centers and facilities.

"(2) In taking actions under paragraph (1), the Secretary shall take into account the results of the evaluation of the security needs at Department medical centers and research facilities required by section 154(b)(1) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (Public Law 107–188; 116 Stat. 631), including the results of such evaluation relating to the following needs:

"(A) Needs for the protection of patients and medical staff during emergencies, including a chemical or biological attack or other terrorist attack.

"(B) Needs, if any, for screening personnel engaged in research relating to biological pathogens or agents, including work associated with such research.

"(C) Needs for securing laboratories or other facilities engaged in research relating to biological pathogens or agents.

"(c) TRACKING OF PHARMACEUTICALS AND MEDICAL SUPPLIES AND EQUIPMENT.—The Secretary shall develop and maintain a centralized system for tracking the current location and availability of pharmaceuticals, medical supplies, and medical equipment throughout the Department health care system in order to permit the ready identification and utilization of such pharmaceuticals, supplies, and equipment for a variety of purposes, including response to a chemical or biological attack or other terrorist attack.

"(d) TRAINING.—The Secretary shall ensure that the Department medical centers, in consultation with the accredited medical school affiliates of such medical centers, develop and implement curricula to train resident physicians and health care personnel in medical matters relating to biological, chemical, or radiological attacks or attacks from an incendiary or other explosive weapon.

"(e) PARTICIPATION IN NATIONAL DISASTER MEDICAL SYSTEM.— Establishment.
(1) The Secretary shall establish and maintain a training program to facilitate the participation of the staff of Department medical centers, and of the community partners of such centers, in the National Disaster Medical System established pursuant to section 2811(b) of the Public Health Service Act (42 U.S.C. 300hh–11(b)).

"(2) The Secretary shall establish and maintain the training program under paragraph (1) in accordance with the recommendations of the working group on the prevention, preparedness, and response to bioterrorism and other public health emergencies established under section 319F(a) of the Public Health Service Act (42 U.S.C. 247d–6(a)).

"(3) The Secretary shall establish and maintain the training program under paragraph (1) in consultation with the following:

"(A) The Secretary of Defense.

"(B) The Secretary of Health and Human Services.

"(C) The Director of the Federal Emergency Management Agency.

"(f) MENTAL HEALTH COUNSELING.—(1) With respect to activities conducted by personnel serving at Department medical centers, the Secretary shall develop and maintain various strategies for providing mental health counseling and assistance, including counseling and assistance for post-traumatic stress disorder, following a bioterrorist attack or other public health emergency to the following persons:

"(A) Veterans.

"(B) Local and community emergency response providers.

"(C) Active duty military personnel.

"(D) Individuals seeking care at Department medical centers.

"(2) The strategies under paragraph (1) shall include the following:

"(A) Training and certification of providers of mental health counseling and assistance.

"(B) Mechanisms for coordinating the provision of mental health counseling and assistance to emergency response providers referred to in paragraph (1).

"(3) The Secretary shall develop and maintain the strategies under paragraph (1) in consultation with the Secretary of Health and Human Services, the American Red Cross, and the working group referred to in subsection (e)(2).".

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 8116 the following new item:

"8117. Emergency preparedness.".

38 USC note prec. 8101.

(b) REPEAL OF CODIFIED PROVISIONS.—Subsections (a), (b)(2), (c), (d), (e), and (f) of section 154 of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (Public Law 107–188; 38 U.S.C. note prec. 8101) are repealed.

38 USC note prec. 8101.

(c) CONFORMING AMENDMENTS.—Subsection (g) of such section is amended—

(1) in paragraph (1), by inserting "of section 8117 of title 38, United States Code" after "subsection (a)"; and

(2) in paragraph (2), by striking "subsections (b) through (f)" and inserting "subsection (b)(1) of this section and subsections (b) through (f) of section 8117 of title 38, United States Code".

Approved November 7, 2002.

LEGISLATIVE HISTORY—H.R. 3253 (S. 2132):

HOUSE REPORTS: No. 107–471 (Comm. on Veterans' Affairs).
SENATE REPORTS: No. 107–229 accompanying S. 2132 (Comm. on Veterans' Affairs).
CONGRESSIONAL RECORD, Vol. 148 (2002):
May 20, considered and passed House.
Aug. 1, considered and passed Senate, amended.
Sept. 17, House concurred in Senate amendment with an amendment pursuant to H. Res. 526.
Oct. 15, Senate concurred in House amendment with an amendment.
Oct. 16, House concurred in Senate amendment.

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Opening Statement
Honorable Rob Simmons
Chairman, Subcommittee on Health
Committee on Veterans' Affairs
March 27, 2003

The Subcommittee will come to order.

Welcome our distinguished witnesses today and I look forward to hearing your testimony.

Two important topics, but very much related –aiding the war on the use of bio-weapons, and protecting deployed military members.

Especially want to be concerned about military forces now serving so well in Iraq, the Philippines, Afghanistan and other troubled places around the world -- before they become veterans.

There are several pertinent topics on the issue of force protection, including:

- Medical Surveillance,
- Pre- and Post-Deployment Health Assessment,
- Environmental monitoring and security,
- Use of Investigational Drugs,
- Vaccination,
- Record keeping and record movement from a military agency to the VA,
- Protective and warning equipment, procedures, systems, and documentation, *in theater* versus *on the memo.*

- Medical care in theater, MEDEVAC, and medical regulating to a CONUS receiving station.

Witnesses here to provide testimony on these topics that are pertinent to force protection and preventive care, safety and readiness.

- Last Congress, under the most able leadership of my colleague from Kansas, Chairman Moran, Subcommittee held hearings to explore lessons learned by Government from earlier wars -- *there were many.*
- How these lessons were -- or were not -- applied to the current deployment of American troops in the Second Gulf War.
- How well DoD and VA *implemented* new policies based on lessons learned from earlier wars.
- This Subcommittee can take a proactive approach to ensure that the men and women of the armed forces are cared for today – now -- while doing their duty overseas, so that as a nation, we might avoid some of the traumas and costly mistakes of past wars.
- Stewardship by Congress, and better leadership by the Administration, can head off untold difficulties that otherwise may lie ahead for veterans of these conflicts, and their families.

Also today Subcommittee will hear testimony on the implementation of Public Law 107-287, the *Department of Veterans Affairs Emergency Preparedness Act of 2002.* The purpose of this Act, introduced under the able leadership of our

Full Committee Chairman, the gentleman from New Jersey, Mr. Smith and our Democratic Ranking Member, the gentleman from Illinois, Mr. Evans, is to use a very small resource investment by the VA to protect veterans and ultimately all of us -- from the effects of uses of terrible weapons in the post 9/11 world.

Congress established this charge in VA because it is a task that can be implemented quickly -- and makes sense. Under this act four Emergency Preparedness Research Centers are established. Each center will organize research programs to address health needs from human exposures to chemical, biological, and radiological substances, as well as incendiary or explosive devices, that may be deployed as weapons on the battlefield or back here closer to home. We know these weapons can be used – they were used in the form of anthrax in New Jersey, New York, Florida, and right here in this Congress in October 2001! How soon we forget.

Congress enacted our bill unanimously, and the President signed it, over a year ago. However, in their wisdom, our friends on the Appropriations Committees decided they have a better approach – to leave this work exclusively to Governor Ridge and the new Department of Homeland Security. So the appropriators put a little prohibition in the massive omnibus bill funding the entire government. It forbids VA from spending any funding on this project for fiscal year 2003. We have a standing rule of the House that prohibits legislation on an appropriations act, but this is what we have done anyway. So the vital work that this Act authorizes was delayed for a year, and we need to examine that impact and what needs to be done to get this back on track.

There could not be a more timely topic.

As we speak, we have put our best men and women at great risk of regular combat with all its horrors, and also in potential contact with weapons of mass destruction. As of last evening there were dozens of wounded soldiers and Marines at Ramstein Air Force Base Hospital in Germany, all injured in the conventional ways of war. Let us hope for their safe return and speedy recovery. They are doing their duty.

We think VA is right for this task because, in addition to its medical care mission, the VA is the nation's largest provider of graduate medical education and a significant contributor to bio-medical and basic sciences research. The VA can be an essential asset in responding to national emergencies and can and does help in heading off, and recovering from, a variety of natural disasters.

It is the hope of the Subcommittee that we may explore a bit of the future of bioterrorism research and readiness in this niche of government called the VA in order to do something good for America's veterans and for America.

Statement of Ciro Rodriguez
Ranking Democratic Member
Health Subcommittee
Committee on Veterans Affairs
Hearing to Status of the Implementation of Public Law 107-287, the Department of Veterans Affairs Emergency Preparedness Act of 2002 and Post Deployment Health Care For Veterans

Thank you, Mr. Chairman. I appreciate you calling this important and very timely hearing today. With troops in the field, it is critical for us to know that the infrastructure and policies are in place to ensure that the health care services they need are readily available to them when they return home.

Sadly, many of us have already experienced war's devastating effects during the relatively brief time we've been engaged in Iraq. In my own district, I've been in contact with the Hernandez family from Mission. Their son, Edgar, is a young soldier who is believed to be one of the prisoners of war we heard about this weekend. I will be praying for his and all our troops' safe return.

We will hear today from the Assistant Secretary of Defense for Health Affairs, Dr. Winkenwerder, who will inform us that many initiatives Congress approved as part of P.L. 105-85 almost six years ago are still "underway." While there's been some progress since the first deployment to the Gulf, I am generally disappointed that so many of the promising tools the Doctor's statement will reference are not going to be available during this deployment. In addition, I believe there are major differences in expectations about how the Department of Defense is implementing various provisions which I am eager to hear Dr. Winkenwerder explain to us in further detail.

We will also be hearing about the value of four medical emergency preparedness centers in the Department of Veterans Affairs Congress authorized in P.L. 107-287. I believe that VA proved its mettle in the wake of 9-11 after which it played vital roles in offering care, counseling and referral services to those who were injured, the first responders, and victims' family members. As the back-up to the Department of Defense, and as part of the Federal Response Plan and National Disaster Medical System, VA has a keen interest in helping our nation plan for and investigate its response to

bioterrorism and define best practices in post-deployment care for our troops.

In this regard, I am proud of the work that is ***already*** being done at the San Antonio VA Medical Center, the Brooks City Base, and the University of Texas Health Science Center at San Antonio. General Harold Timboe is joining us to tell us more about the activities already being undertaken by this consortium and some of the unique resources they have at their disposal to advance the nation's research and agenda for counter-terrorism efforts and for planning to serve our veterans who return home ill after their service in the Gulf. Without stealing any of your thunder, General, I just want to mention the joint Research Imaging Center with its state-of-the-art equipment which is a cooperative venture between the VA, DOD and the University, the protein core facility, and the advanced health care services offered by VA and the Health Science Center which I believe make it poised to make invaluable contributions in this area.

General Timboe is a decorated combat veteran of both Vietnam and the first Gulf War. He is actually a distinguished alumnus of University of Texas Health Science Center at San Antonio and has held leadership positions at progressively more complex health systems throughout his career, ending his military career as the lead medical officer at one of the nation's military flagships here in our own backyard, Walter Reed Army Medical Center, as well as commanding the North Atlantic Regional Medical Command.

Since this July, the General has assumed responsibilities at the Health Science Center which will include overseeing its involvement in homeland defense, bioterrorism research, and its partnership with military medicine, including VA. I look forward to his testimony.

We are a nation at war. We cannot afford ***not*** to take advantage of every potential opportunity to advance our knowledge in addressing bioterrorism and the health of our returning troops. We need the bioterrorism centers your bill created Chairman Smith and I am ready to work with you to ensure that they are funded and implemented.

Prepared Statement

of

The Honorable William Winkenwerder, Jr., M.D., M.B.A.

Assistant Secretary of Defense for Health Affairs

on

Oversight Hearing on Bioterrorism Research and Post Deployment Health Care for Veterans

Before the
Subcommittee on Health
House of Representatives Committee on Veterans Affairs

March 27, 2003

Mr. Chairman and members of this distinguished committee, thank you for the opportunity to be here today and thank you for your continuing support of the men and women who have served in our Armed Forces.

As the Assistant Secretary of Defense for Health Affairs, safeguarding the health and safety of our military members is my highest priority. Our Force Health Protection program has made great strides, based on the lessons learned from Operation Desert Storm. I believe our efforts are in line with your own objectives, as expressed in Public Law 105-85. Force Health Protection is a strategy that applies to the continuum of medical care experienced by each Service member from entrance into the military to separation from the military and transition in many cases to the VA healthcare system. The vigorous requirements of the medical entrance physical examination, the periodic physical examinations, periodic HIV screening, annual dental examination, physical training and periodic testing, and the regular medical record reviews are parts of this continuum.

In order to clarify our program, I will address the requirements of Public Law 105-85 individually, and then explain our actions that go beyond what that law requires.

Public Law 105-85 - Section 765 (a) - Improved tracking system

Our actions are based on two primary medical tracking policy documents. DoD Instruction 6490.3, August 7, 1997, *Implementation and Application of Joint Medical Surveillance for Deployments*, implements policy and procedures, and assigns responsibilities for joint military medical surveillance in support of all applicable military objectives. It describes routine military medical surveillance activities during major deployment, or deployments in which there is a significant risk of health problems. *Updated Procedures for Deployment Health Surveillance and Readiness* provides standardized procedures for assessing health readiness and conducting health surveillance in support of all military deployments.

Based on those policies, the DoD has taken steps to improve deployment-related medical record keeping by developing the Composite Health Care System II (CHCS II) and the Theater Medical Information Program (TMIP), and by expanding the electronic tracking and centralized collection of immunization data. Electronic tracking of immunizations was initially implemented for the Anthrax Vaccine Immunization Program (AVIP) in 1998, using Service-specific automated systems. Efforts are underway by the Services to electronically track all immunizations and to centralize collection of immunization data for surveillance and research purposes.

The Defense Medical Surveillance System (DMSS) has been established under the Army Center for Health Promotion and Preventive Medicine (CHPPM) to provide improved DoD joint health surveillance capabilities. Operated by the Army Medical Surveillance Activity (AMSA), the DMSS database contains historical and up-to-date data on diseases and medical events such as hospitalizations, and ambulatory visits, as well as longitudinal data on personnel and deployments.

The Services have begun implementation of health surveillance and computerized medical record keeping during deployments, allowing for surveillance of health events as well as documentation of health care and countermeasures utilized during deployment. The TMIP, which is currently undergoing testing, will gather individual medical information throughout operational deployments. This information will help to document deployment-related health problems and can be shared with the VA to facilitate continuity of care for veterans.

In the past few months, DoD has developed and implemented the Joint Medical Work Station. This is the most recent addition to our capability to monitor the health status of our deployed forces. Using the Force Health Protection portal to our classified system, DoD now has the electronic capability to capture and disseminate near real-time information to commanders about in-theater medical data, patient status, environmental hazards, detected exposures and critical logistics data such as blood supply, beds and equipment availability.

For longitudinal study, one important health surveillance initiative prompted by post-Gulf War health issues is the monitoring of birth defects among DoD beneficiaries through establishment of a birth defects registry. This registry has been established and is a valuable resource. Another is the use of the DoD Serum Repository for routine and pre-deployment collection and storage of serum specimens, which are subsequently available for analysis regarding military- and deployment-related health concerns.

In addition, the Millennium Cohort Study is an ongoing comprehensive DoD health research initiative that responds to concerns about whether deployment-related exposures are associated with post-deployment health outcomes. A cross-sectional sample of 100,000 military personnel and veterans will be studied prospectively over a 21-year period.

Section 765 (b) - Predeployment medical examinations and postdeployment medical examinations

The DoD has instituted a deployment health surveillance program that includes pre-deployment and post-deployment health assessments which documents individuals' medical readiness to deploy and address health concerns upon their return, along with improved occupational and environmental health surveillance programs for protecting Service members' health during deployment.

Deploying personnel receive individual health assessments that are documented on DD Form 2795, Pre-Deployment Health Assessment. Individual pre-deployment health assessments include eight questions and further include reviews of required immunizations and other protective medications/measures, personnel protective and medical equipment, DNA and serum (HIV) samples (preserved in the DoD Serum repository), dental classification, and briefings on deployment-specific health threats and countermeasures.

Redeploying personnel receive individual health assessments that are documented on DD Form 2796, Post-Deployment Health Assessments. These assessment forms include questions on health and exposure concerns. Medical personnel review the forms and positive responses result in a review of deployment health records and appropriate referral for follow-up care.

Follow-up health care is also available through military and VA providers using the jointly-developed Post-Deployment Health Clinical Practice Guideline, which has been designed specifically for addressing deployment-related health concerns. The guideline provides a structure for the evaluation and management of Service members and veterans with deployment-related concerns. It also provides access to expert clinical support to physicians and other health care professionals for patients with challenging symptoms and illnesses, and may provide a useful platform for research into post-deployment health concerns. The post-deployment health care process is managed by the DoD Deployment Health Clinical Center (DHCC) located at Walter Reed Army Medical Center.

Section 765 (c) - Improved medical record keeping

The original deployment health assessment forms are placed in the Service member's permanent medical record. Copies of the forms are sent to the Army Medical Surveillance Activity, where the forms are scanned and the data entered into the Defense Medical Surveillance System for archiving and analysis.

Immunizations are tracked by specific systems within the Services and the data is fed into the Defense Eligibility Enrollment Reporting System (DEERS). The Army's Medical Protection System (MEDPROS), and the Navy's Shipboard Automated Medical System (SAMS) are partially implemented. The Air Force Comprehensive Immunization Tracking System (AFCITA) is fully implemented. We have developed DD Form 2766 as the standard form in the medical record for recording essential readiness indicators. This form accompanies the deploying Service member.

We are currently transitioning from paper based medical records to automated medical records for patient encounters and disease non-battle injury (DNBI) reporting.

Section 765 (d) - Quality assurance

Currently, quality assurance is being executed by the individual Services. The Air Force has included deployment health quality assurance in their medical Inspector General inspection checklist. The Army Surgeon General has recently sent out a memo requiring audits of medical surveillance records.

Our Deployment Health Support Directorate is in the process of developing DoD-wide systems for quality assurance of medical record keeping and medical surveillance data.

Section 767 - Tracking Service member location

As previously reported, TMIP has been partially implemented and DoD has implemented an interim deployment medical surveillance system, the force health protection portal. In the future, TMIP developments will tie into the Defense Manpower Data Center that will capture data on unit and individual locations. TMIP will also tie into operational, personnel and medical data systems that will capture information on possible harmful exposures or health related events. The Defense Integrated Military Human Resource System (DIMHRS) will ultimately receive and archive both medical and personnel information. DIMHRS is several years away from implementation, but an interim solution is in progress. DoD is also in the process of developing individual medical readiness standards and looking at developing a comprehensive DoD health surveillance system.

Section 768 - Specialized units for monitoring chemical/biological hazards

The DoD now routinely deploys preventive medicine, environmental surveillance, and forward laboratory teams in support of worldwide operations. For example, the Army's Center for Health Promotion and Preventive Medicine (CHPPM) conducts pre- and during-deployment environmental health intelligence studies for the battlefield, and performs extensive environmental assessments of operationally selected staging areas and base sites. CHPPM also supplies environmental sampling materials for deployed forces, conducts operational risk management estimates for field commanders, and develops pocket-sized "staying healthy" guide books for deployed Service members.

Additional efforts

Beyond the actions required by Congress, DoD has taken several steps that we believe to be vital for the protection of the health of deployed service members. For example, the DoD has established three deployment health centers. One is focused on deployment health surveillance, another on deployment health care, and the third on deployment health research. These centers are concentrating their efforts on the prevention, treatment, and understanding of deployment-related health concerns.

The DoD has improved health risk communication through the provision of regionally specific medical intelligence, environmental risk assessments, medical threat briefings, pocket-sized health guides, and deployment-focused web sites.

We are developing improved health protection measures to counter an increasingly broad range of threats. Such measures include the fielding of new biological and chemical warfare agent detection and alarm systems; the operational testing of integrated electronic medical surveillance and emergency response networks; current vaccines and anti-malarial drugs; and research on the next generation vaccines and pharmaceuticals.

In addition to pre- and post-deployment health assessments, the military medical departments incorporate routine health and medical readiness appraisals to ensure service members meet and maintain health standards. A complementary effort is underway to develop standardized DoD-wide individual medical readiness indicators.

Mr. Chairman, this concludes my statement. I thank you and the members of this committee for your outstanding and continuing support for the men and women of the Department of Defense.

Statement of
The Honorable Robert H. Roswell, M.D.
Under Secretary for Health
Department of Veterans Affairs
Before the
House of Representatives
Committee on Veterans' Affairs
Subcommittee on Health
on the
"Status of the Implementation of Public Law 107-287 and
VA-DoD Efforts to Coordinate Force Protection in the Active Duty Military
****
March 27, 2003

Mr. Chairman, I am pleased to be here to testify before the Subcommittee on the "Status of the Implementation of Public Law 107-287 and VA-DoD efforts to coordinate force protection in the active duty military. With me today is Dr. Susan Mather, VA's Chief Officer for Public Health and Environmental Hazards. I will first address implementation of the provisions of Public Law 107-287.

Public Law 107-287 authorizes VA to furnish health care to victims during national disasters and emergencies declared by the President or when the National Disaster Medical System (NDMS) is activated. The law contains several other provisions intended to enhance VA's ability to identify, diagnose, respond to or prevent the medical consequences resulting from the use of weapons of mass destruction (WMD).

Implementation of the provisions of Public Law 107-287 has progressed more slowly than had been anticipated, due in large part to the uncertainty concerning language in VA's FY 2003 appropriations bill. Section 117 of H.R. 5605, as passed by the House, included language that would have prohibited the use of FY 2003 appropriations for implementation of all provisions of H.R. 3253, which was subsequently signed into law as Public Law 107-287. However, the final language enacted on February 20, 2003, prohibited the use of funds provided for FY 2003 for implementation of only sections 2 and 5 of Public Law 107-287. Accordingly, VA is now actively pursuing implementation of the "non-prohibited" provisions.

Section 2

Section 2 authorizes VA to establish four medical emergency preparedness centers with a mission to carry out research, education, to develop methods of detection, diagnosis, prevention, and treatment of injuries, diseases,

and illnesses arising from the use of chemical, biological, radiological weapons posing threat to public health and safety. As discussed above, VA's appropriations act specifically prohibits any funds provided for FY 2003 from being spent on these centers. We continue to work with other agencies such as DoD, HHS, and DHS in our emergency preparedness role.

Section 3

Section 3 requires VA to carry out a program to develop and disseminate a series of model education and training programs on the medical responses to the consequences of terrorist activities. That section further requires these programs to be modeled after programs established at DoD's Uniformed Services University of the Health Sciences and shall include, at a minimum, include emergency preparedness training for health care professionals. Their content must include, among other things, training in the recognition of chemical, biological, and radiological agents that may be used in terrorist activities and identification of potential symptoms related to use of those agents. The training would also be required to address short-term and long-term health consequences, including psychological effects that may result from exposure to such agents and the appropriate treatment of those health consequences.

The programs must be designed for a wide range of health care professionals at all levels. To date we have developed satellite broadcasts covering biological and chemical warfare issues as well as other educational tools and programs for those who may be charged to render care for victims of terrorist incidents. Through our education infrastructure, we will share and disseminate these programs widely.

Involvement of education and training experts and representatives from involved disciplines/target groups is also essential as we continue to organize and develop a comprehensive education and training response. To this end, we have already held preliminary meetings with representatives from the Uniformed Services University of Health Sciences to explore collaborative endeavors. We intend to assemble a committee of experts to further develop a plan to address priority educational needs through the use of multiple modalities. In the meantime, we have conducted several excellent videoconferences on WMD produced by DoD; further, we taped those videoconferences to have training videos for future use.

Section 4

Section 4 authorizes VA to furnish health care to persons responding to, involved in or otherwise affected by (including veterans), major disasters and medical emergencies. Formal mechanisms for VA health care of DoD casualties

have been in place since the 1980's.

Under § 8111A of title 38, United States Code, VA has a "fourth mission" - to serve as principal health care backup to DoD in the event of war or national emergency. Plans were developed jointly by VA and DoD to establish a VA/DoD Contingency Hospital System. An important objective of the planning effort is to assess VA's bed capacity to care for sick and wounded Armed Forces personnel in time of war or national emergency. VA medical centers assess five specific bed categories (Critical Care, Medical-Surgical, Psychiatry, Pediatrics, and Burn) required by DoD. Assessments take into account the impact on local operations of VA employees subject to mobilization.

VA's objective is to provide DoD with maximum bed availability in the specific contingency bed categories within 72 hours of activation of the VA/DoD Contingency Hospital System. VA may arrange care for some patients at civilian community hospitals or through activation of the NDMS. Secondary Support Centers (SSCs) would provide backup to the Primary Receiving Centers (PRCs) by accepting transfers of patients or by providing staff and other resources. Fifty-eight VAMCs and three outpatient clinics have been classified as Installation Support Centers. The Installation Support Centers could assist a neighboring DoD installation or medical facility with clinical needs during a military mobilization.

A system is in place to recover the costs of health care provided to DoD beneficiaries in such events. Furthermore, VA is developing an implementation plan to establish and support the business requirements at all VA medical centers, including information technology changes and registration and billing requirements during and immediately following a disaster or emergency.

As to the NDMS, in 1997, VA signed a Memorandum of Understanding with the Federal Emergency Management Agency, Department of Health and Human Services, and DoD, continuing the NDMS partnership. One of the NDMS missions is to provide a civilian backup component to the VA/DoD Contingency Hospital System, if needed. This is accomplished through care at civilian hospitals enrolled in NDMS and allows for DoD casualties to be treated at these facilities when DoD and VA health care facilities reach capacity.

VA medical facilities regularly test and upgrade emergency response plans through training and exercises, including conducting quarterly bed reporting exercises of available staffed VA beds, as well as bed reporting exercises of available staffed NDMS-enrolled civilian beds.

In the aftermath of the September 11, 2001, attacks in this country, VA and DoD have partnered in many ongoing initiatives that focus on diagnosing and treating casualties of potential domestic terrorist events. Examples include VA-DoD exercises and training on casualty reception and care, jointly sponsored

satellite broadcasts on weapons of mass destruction and DoD-hosted training for VA and DoD NDMS Federal Coordinators. In addition, VA's office of Policy, Planning and Preparedness interfaces with counterparts at DoD, HHS, and other agencies involved in national preparedness initiatives, and the VA-DoD Health Executive Council Deployment Health Working Group regularly addresses issues of mutual concern and interest.

Section 5

Mr. Chairman, as stated above, VA may not use any of its FY 2003 appropriations to establish the new position of an Assistant Secretary overseeing operations, preparedness, security, and law enforcement functions. However, that has not precluded activities to ensure the protection of VA facilities, employees, and patients.

A security workforce of over 2,000 personnel, including police officers and detectives, currently protects VA medical and research facilities. Department security and law enforcement policy is established and overseen by the Office of Security and Law Enforcement (OS&LE). OS&LE has conducted numerous studies of security vulnerabilities and police officer staffing needs in the last twelve months. In addition, we are reviewing the findings of contracted vulnerability assessments and other data developed as a result of Public Law 107-188. As a result, we have taken the following actions.

- As part of the President's 2004 Budget Submission, VA has requested additional funds to fortify the Department's police force.
- We are developing a new Department-wide policy addressing personnel suitability and security screening requirements. The appropriate sections of the USA Patriot Act will be included this policy.
- OS&LE worked with a multi-agency work group and developed specific physical security requirements for research and clinical laboratories. These requirements were communicated to VHA field facilities and are checked for compliance during routine police program inspections. The requirements will also be included in the next revision of security policy.

Section 6

Section 6 was a codification of already existing authorities. These authorities focus on VA's ability to respond to a terrorist attack involving use of WMD that could occur in the community of any VA medical center.

VA has developed policies and directives that address the appropriate response to a WMD attack occurring nearby, but not directly on, a VA medical center. VA has also provided specific policy to VA facilities on the key steps required to implement an appropriate medical center emergency mass-casualty

decontamination capability based upon local and community needs as part of a decontamination plan. The intent of those policies and guidelines are to protect the veterans, the facilities, and VA staff, and to provide appropriate care to victims of such an attack who may present at a VA medical center within 24 hours of an incident.

We have selected seventy-eight medical centers for implementation of VA's mass-casualty decontamination program during the next 12 months. These facilities have submitted a list of four core decontamination team members who will receive a one-week training course on decontamination operations and on how to provide the same training to the other decontamination team members at their facilities.

An inaugural VA Decontamination Training Course was held March 10-14, 2003 in Reno, Nevada. The week-long session offered three days of basic emergency hospital decontamination operations, and two days of a train-the-trainer program that gives trainees important skills to take back to their facility. Twenty-four staff from six VA medical centers completed the course. Subsequent training courses will be held at the Little Rock, AK and Bay Pines, FL VA medical centers.

Upon completion of the core-training program, facilities will be able to purchase the type and amount of decontamination units, and the personal protective equipment that they will need for their program. VA's Office of Acquisition and Materiel Management is currently soliciting vendors to supply this equipment. The core-training program includes guidance necessary to evaluate and identify the range of equipment best suited to individual medical center needs.

VA has established an extensive system to deploy, track, and restock pharmaceutical caches to ensure resources are available to respond to chemical, biological, and radiological attack or other terrorist attacks, as well as respond to a WMD attack within the first 72 hours. VA uses delivery of pharmaceuticals through a centrally controlled tracking system of medical supplies, equipment, and pharmaceutical inventories. The pharmaceutical stockpiles at VA medical centers lessen the time required to obtain critical medical and surgical supplies from external caches such as the National Pharmaceutical Stockpile (NPS) or from usual procurement sources.

VA has developed strategies for providing mental health counseling and assistance, including counseling for Post-Traumatic Stress Disorder, to any individuals who seek care at VA facilities following bioterrorist attack or other public health emergency. In preparation for providing these services, VA provides training for VA staff and mechanisms for providing care in a coordinated fashion.

The best way to combat harmful emotional effects of such attacks is through providing accurate information to the affected population and through efficient coordination of response to the attack. The clinical mental health role involves accurate diagnosis to differentiate delirium due to the physical effect of an agent from acute stress reactions or psychotic states. It involves the recognition of acute stress reactions, other anxiety disorders, grief and bereavement, and depressive disorders. In the aftermath of an attack, most individuals should be expected to recover from acute emotional responses to the fear and stress of an attack. Clinicians must be alert, however, to detect those who have persisting symptoms of stress, anxiety, depression, and the risk of substance abuse in an attempt to deal with their symptoms.

Over the past several years, VA has created a number of satellite presentations on management of casualties from biological and chemical attack. In the first week of April 2003, VA will broadcast two satellite programs designed to address management of possible casualties of the current war with Iraq. In addition, web-based materials will be made available to VA clinicians addressing both the physical and mental health aspects of war injuries. Issues of biological attacks will be included, since the skills required to deal with these types of injuries and issues in combat casualties are, in most cases, identical to those needed in response to a terrorist attack. We will, over the next weeks and months of 2003, train our mental health clinicians, using approaches acknowledged by our colleagues in HHS, DoD, and the American Red Cross to be most effective in managing response to terrorism. We will create in our Networks an infrastructure of trained clinicians, enduring educational materials, and local and national coordination to ensure that veterans, emergency responders, and others who come to VA for care in the event of a terrorist attack receive the help they need.

Mr. Chairman, I would now like to turn my attention to issues involved in force protection for the active duty military forces. Because nearly 250,000 U.S. troops are engaged in renewed conflict in the Gulf region, I am grateful for the opportunity to emphasize that VA today is better prepared to provide high quality health care and disability assistance than at any other time in our history. Since Operations Desert Shield/Desert Storm in 1991, VA has developed and implemented the following policies and programs in response to the lessons learned from that conflict.

Health Care, Surveillance, Education, and Outreach

Health Care following Combat

It is critical to provide informed, knowledge-based health care after every war. Congress has shown an appreciation for the importance of providing health

care for combat veterans. Under 38 U.S.C. § 1710(e)(1)(D), added by Public Law 105-368, VA is authorized to provide health care for a two-year period to veterans who served on active duty in a theater of combat operations during a period of war after the Gulf War, or in combat against a hostile force during a period of hostilities after November 1, 1998. Under this provision, veterans of combat now have a two-year period of access to VA health care for any illness, regardless of whether there is sufficient medical evidence to conclude that the illness is attributable to that service. An exception to this general rule occurs when VA has found that a particular condition is not due to the period of service in question. Veterans of the current conflict with Iraq will be eligible for health care under this provision of law.

In addition to providing needed health care, VA has the capability to collect and analyze information on the health status and health care utilization patterns of veterans. The capability to collect this basic health information helps us evaluate specific health questions, such as determining the causes of difficult-to-explain symptoms experienced by some veterans returning from certain combat theaters or areas of hostilities. VA's medical record system now permits patient health information to be tracked for special groups of veterans. Moreover, standard health care databases allow VA to evaluate the health care utilization of veterans every time they obtain care from VA, not just on the one occasion that they elect to have a registry examination, as was the practice in the past. This will provide a much broader and longer-term assessment of the health status of these veterans because many veterans return frequently for VA health care and are often seen in different clinics or even different parts of the country for specialized health care.

Ensuring High Quality Post-Deployment Health Care

Specialized health care during the post-deployment period can help prevent long-term health problems. Therefore, VA has developed evidence-based clinical approaches for treating veterans following deployment. Newly developed Clinical Practice Guidelines (CPG's), which are based on the best scientifically supported practices, give health care providers the needed structure, clinical tools, and educational resources that allow them to diagnose and manage patients with deployment-related health concerns. Two post-deployment CPG's have been developed in collaboration with DoD, a general purpose Post-Deployment CPG and a CPG for unexplained fatigue and pain. Our goal is that all veterans who come to VA will find their doctors to be well informed about specific deployments and related health hazards. Information on Clinical Practice Guidelines are available online at www.va.gov/environagents. This web site also contains information about unique deployment health risks and new treatments.

Assessment of Difficult-to-Diagnose Illnesses

We have learned that sustained clinical care and research is needed to understand post-deployment health problems. Congress also understood this need and in legislation enacted as Public Law 105-368 required establishment of a plan to develop national centers for the study of war-related illness and post-deployment health issues. Subsequently, in 2002, VA established two such centers, known as "War-Related Illness and Injury Study Centers" (WRIISC's), in East Orange, NJ, and Washington, DC, to provide specialized health care for veterans from all combat and peace-keeping missions who suffer difficult-to-diagnose but disabling illnesses. These centers are available through referral to veterans from all eras, including veterans of a future war with Iraq. These centers also provide research into better treatments and diagnoses, develop education programs for health care providers, and develop specialized health care programs to meet veterans' unique needs, such as the National Center for PTSD.

The majority of veterans returning from combat and peacekeeping missions are able to make the transition to civilian life with few problems. Most who come to VA for health care receive conventional diagnoses and treatments, and leave satisfied with their health care. Nevertheless, VA has learned that some veterans have greater problems on their return to civilian life, and a small percentage of them develop difficult-to-diagnose symptoms. The two WRIISC's focus on determining the causes and most effective treatments for difficult-to-diagnose symptoms -- problems seen in veterans of all wars. More information on the WRIISC's can be found at the VA website, www.va.gov/environagents.

Veterans Health Initiative

VA has built upon the lessons learned from our experiences with Gulf War and Vietnam veterans' programs to implement an innovative new approach to health care for veterans. The Veterans Health Initiative (VHI) is a comprehensive program designed to increase recognition of the connection between military service and certain health effects, to better document veterans' military and exposure histories, to improve patient care, and to establish a database for further study.

The education component of VHI prepares VA healthcare providers to better serve their patients. We have completed modules on spinal cord injury, cold injury, traumatic amputation, Agent Orange, the Gulf War, PTSD, blindness/visual impairment and hearing loss, and radiation. We are currently developing modules on infectious disease health risks in Southwest Asia, sexual trauma, traumatic brain injury, and military occupational lung disease. These important tools are integrated with other VA educational efforts to enable VA practitioners to more quickly and accurately arrive at a diagnosis and to provide

more effective treatment.

Enhanced Outreach

Outreach is critical, and the Gulf War made clear the value of timely and reliable information about wartime health risks for veterans and their families, elected representatives, the media, and the nation at large. VA has already developed a brochure that addresses the main health concerns for military service in Afghanistan and is preparing another brochure for the current conflict in the Gulf region. These brochures answer health-related questions that veterans, their families, and health care providers have about these hazardous military deployments. They also describe relevant medical care programs that VA has developed in anticipation of the health needs of veterans returning from combat and peacekeeping missions abroad.

Another challenge for outreach is to address the specific concerns of veterans and their families over the potential health impact of environmental exposures during deployment. Veterans also have questions about their symptoms and illnesses following deployment. These concerns are addressed through newsletters and fact-sheets to veterans covering health and compensation issues, including environmental health issues; regular briefings of veterans service organizations; organization of national meetings on health and research issues; media interviews; other educational material and websites with information, like www.va.gov/environagents.

Recruit Assessment Program (RAP)

Based on the Department's experience providing health care and benefits to Gulf War veterans, VA recognizes the critical importance of health documentation and life-long medical records that cover pre-, during-, and post-deployment period. Previously, new health problems among Gulf War veterans were not readily verifiable due to a lack of detailed computerized records documenting enlistment and pre-deployment health status. Research efforts to understand Gulf War veterans' illnesses were also hampered by inadequate base-line health information, and inadequate documentation of health status during active duty.

DoD and VA have recognized these shortcomings and are attempting, through development and implementation of the Recruit Assessment Program (RAP), to collect comprehensive baseline health data from all U.S. military recruits. The RAP is a DoD program, which is under development with the support of VA. The goal is for the RAP to be the first module of a life-long health record for military personnel and veterans. The RAP will help DoD and VA to evaluate health problems among service-members and veterans after they leave military service, to address post-deployment health questions, and to document changes in health status for disability determination.

It is important to note that during the last two years all U.S. Marine Corps recruits initially trained on the West Coast have completed a RAP questionnaire as part of a pilot RAP development program. Therefore, baseline health data is available for over 31,000 Marines, many of whom are currently serving in the Gulf region.

VA Vet Center Program

VA's Vet Centers, originally conceived to provide a wide variety of readjustment services to Vietnam veterans, have been invaluable in providing similar services to veterans from more recent combat and peacekeeping missions. More than 115,000 veterans of Operations Desert Shield/Desert Storm have made use of their services. We fully expect that the VA Vet Centers will be available to help both veterans of the current hostilities in Afghanistan and Iraq and veterans of future conflicts elsewhere in the world.

Disability Compensation

To assist in disability determinations, VA has actively worked with DoD to develop separation physical examinations that thoroughly document a veteran's health status at the time of separation from military service and that also meet the requirements of the physical examination needed by VA in connection with a veteran's claim for compensation benefits. VA has also worked to provide fair compensation for Gulf War veterans with difficult-to-diagnose illnesses. Under 38 U.S.C. § 1117 (as amended by Public Law 107-103), VA has authority to compensate Gulf War veterans for chronic disabilities resulting from an undiagnosed illness or certain medically unexplained chronic multisymptom illnesses. It is our belief that service members serving in the Southwest Asia Theater of Operations during the current conflict with Iraq would, as veterans, also be eligible for compensation for disabilities resulting from undiagnosed illnesses.

Coordination with the Department of Defense

Enhanced Interagency Collaboration

One of the important lessons learned from addressing Gulf War health issues was the need to significantly increase intergovernmental coordination among VA, DoD, and Department of Health and Human Services (HHS). The initial Government response to Gulf War veterans' concerns about their illnesses was not effectively coordinated among these Departments. As a consequence, the Persian Gulf Veterans Coordinating Board (PGVCB) was established in January 1994. This board, consisting of representatives from VA, DoD, and HHS, was created to coordinate Federal efforts in the areas of research, clinical care, and benefits. The initiation in 2000 of the tri-agency Military and Veterans Health Coordinating Board (MVHCB), replacing the PGVCB, served to

institutionalize future interagency cooperation. In 2002, the MVHCB was disbanded and a special deployment-health working group of the VA-DoD Health Executive Council was established to further its work and ensure continued interagency coordination for all veteran and military deployment health issues. Governmental coordination will continue to play a critical role in addressing health problems among veterans in future conflicts and peacekeeping missions.

Increased collaboration has also extended beyond America's borders and strengthened coordination with Military and Veterans Affairs agencies in other countries. On post-war health issues, such as those arising after Operations Desert Shield/Desert Storm, VA scientists and policy makers collaborate and share lessons learned with their counterparts in Canada, the United Kingdom, and Australia. Because of the similarity of health problems among war veterans of different countries, these collaborations have focused on difficult-to explain-symptoms that consistently arise among military personnel returning from hazardous deployments.

Transmission of Health Data between DoD and VA

VA and DoD are closely collaborating to develop the ability to share medical information electronically. Recently, the VA/DoD Joint Executive Council and Health Executive Council approved the adoption of the Joint VA/DoD Electronic Health Records Plan. This Plan provides for the exchange of health data and development of a common health information infrastructure and architecture supported by common data, communications, security and software standards, and high performance health information systems. Since June 2002, the Departments have successfully been sharing electronic medical information. Key initiatives in the Electronic Health Records Plan are the Federal Health Information Exchange (FHIE) and Health*e*People (Federal).

FHIE (formerly known as the Government Computerized Patient Record) provides historical data on separated and retired military personnel from the DoD's Composite Health Care System (CHCS) to the FHIE Data Repository for use in VA clinical encounters, and potential future use for aggregate analysis. Patient data on laboratory results, radiology reports, outpatient pharmacy information, and patient demographics are now being sent from DoD to VA via secure messaging. This first phase of FHIE is fully deployed and operational at VA medical centers nationwide. The next phase is currently being deployed and includes admission discharge transfer data, discharge summaries, allergies, and consult tracking.

Health*e*People (Federal) is a strategy to achieve full interoperability among Federal health information systems, starting with the ability to provide a two-way exchange of health-related information between VA and DoD by 2005. VA and DoD are collaborating on several important health information

applications in moving toward HealthePeople (Federal). Taken together, they will permit the Departments to offer a seamless electronic medical record.

- Clinical Data Repository/Health Data Repository (CHDR): This project seeks to ensure the interoperability of the DoD Clinical Data Repository with the VA Health Data Repository by FY 2005.
- Consolidated Mail-Out Pharmacy: The Departments are testing a system that allows VA to refill outpatient prescription medications from DoD's Military Treatment Facilities.
- Lab Data Sharing and Interoperability: VA and DoD are testing an application that will allow both Departments to combine resources and provide laboratory services to one another.
- Credentialing: A project team has identified common credentialing data to be exchanged between the DoD and VA. Software is being jointly developed and there are plans to begin testing at three sites by 4th Quarter FY 2003. This will decrease the time and resources needed to credential providers who need to practice in both health care systems.
- Scheduling: VA and DoD are sharing technical requirements to ensure interoperability between scheduling applications of each Department. This will allow providers to see all appointments a patient might have scheduled at both VA and DoD facilities and, where authorized, to schedule appointments in each other's clinics.
- E-portal Systems: The Departments are collaborating on a joint acquisition of health content for their electronic web portal systems. This will provide uniform patient health information to VA and DoD beneficiaries.

Deployment Health

VA applauds the efforts of DoD to prevent health problems among deployed troops and to provide immediate care for combat casualties. However, just as DoD has made substantial progress preventing morbidity and mortality on the battlefield, we also need to focus greater attention on the long-term health problems of veterans after the war. The trauma of warfare has lasting effects. The physical and psychological wounds of war can heal slowly, and toxic exposures on the battlefield may have enduring health consequences long after the actual war has ended.

The key to addressing the long-term needs of veterans is to improve medical record-keeping and environmental surveillance. To provide optimal health care and disability assistance after the current conflict with Iraq, VA needs the following:

- A complete roster of veterans who served in designated combat zones; and

- Data from any pre-deployment, deployment, or post-deployment health evaluation and screening of deployed troops.

Furthermore, in the event Iraq uses weapons of mass destruction against U.S. troops, it will be vital for VA to have as much health and environmental information as possible on potential exposures and their health effects in order to provide appropriate health care and disability compensation for veterans of this conflict. Ideally, information would be available from representative environmental samples, biological samples obtained from exposed troops, clinical data from exposed troops who seek medical care, and data from an epidemiological survey of symptoms and illnesses among potentially exposed troops.

Conclusion

Mr. Chairman, this concludes my statement. Let me say again that I am grateful for this opportunity to address the progress has made in implementing the provisions of Public Law 107-287 and to share with you the lessons we have learned to improve the programs and policies we have developed to be better prepared for U. S. service members returning from combat and peacekeeping missions overseas. Dr. Mather and I will now be happy to respond to any questions that you or other members of the Subcommittee might have.

STATEMENT OF
PETER S. GAYTAN, PRINCIPAL DEPUTY DIRECTOR
VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
DEPARTMENT OF VETERANS AFFAIRS (VA) EMERGENCY PREPAREDNESS ACT OF 2002 AND FORCE HEALTH PROTECTION

MARCH 27, 2003

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to present The American Legion's views on the implementation of Public Law 107-287, the *Department of Veterans Affairs Emergency Preparedness Act of 2002* and VA-DOD efforts to coordinate force protection in the active duty military forces of the United States. With our armed forces currently fighting a war in Iraq and the use of chemical weapons a major threat, not only to overseas troops but also to civilians within our borders, these topics are of vital importance and we commend the Subcommittee for holding this hearing.

After the terrorist attacks of September 11, 2001, there was a renewed interest in the nation's ability to adequately respond to a national emergency. Within that scope, the importance of VA's fourth mission, as principal medical care back up for military health care, was brought to the forefront. The role of VA in a national emergency as specifically stated under title 38, United States Code, §8111A is, "during and immediately following a period of war, or a period of national emergency declared by the President or the Congress that involves the use of the Armed Forces in armed conflict, the Secretary may furnish hospital care, nursing home care, and medical services to members of the Armed Forces on active duty." It is the responsibility of Congress to ensure VA is provided the funding and the resources necessary to accomplish that mission.

Under the National Disaster Medical System (NDMS) and the Federal Response Plan (FRP) VA's specialized duties entail:

- Conducting and evaluating disaster and terrorist attack simulation exercises;
- Managing the nation's stockpile of pharmaceuticals for biological and chemical toxins;
- Maintaining a rapid response team for radiological releases; and
- Training public and private NDMS medical center personnel around the country in properly responding to biological, chemical, or radiological disasters.

In response to the tragic events of September 11, 2001 VA quickly mobilized employees to assist in answering questions, providing mental health services, filing for benefits, and assisting with

burial arrangements for the victims. VA also worked jointly with the Federal Emergency Management Agency (FEMA), the Office of Crime Victims (OCV), American Airlines and the American Red Cross. VA's National Center for Post-Traumatic Stress Disorder (PTSD) sent six team members from the Palo Alto Education Division to the Pentagon Family Assistant Center within days of the attacks. This team provided psychological support and education to the recovery workers and family members. For many weeks following the aftermath of 9/11, VA maintained a presence at the Pentagon and in New York to provide much needed services.

In the wake of the September 11th terrorist attacks it became clear that a first responders network was needed to address possible casualties as a result of the potential use of weapons of mass destruction. The VA healthcare system again became the focus of this mission as part of the comprehensive plan for homeland security. Testimony offered by the former Assistant Secretary of Defense for Health Affairs, Dr. Sue Bailey, October 15, 2201, outlined critical needs for that system that acknowledged VA's role.

A coordinated surveillance, identification, containment, communication, and response system will be necessary to minimize the effects of a biologic, chemical or conventional mass casualty incident. Essential facets of such a system would include:

· Adequate communications support between headquarters and field offices and on-site systems.

· Integrated communications among detection units, laboratories, ***first responders***, health care facilities, and federal agencies.

· Adequate detection equipment and enhanced laboratory capacities.

· Coordinated nation-wide medical surveillance for near real-time trend analysis.

· Accelerated specialized training of health care providers, ***first responders***, and other personnel.

· Increased protection for ***first responders*** and facilities.

· Ensured access to stockpiled medications and vaccines.

· Decontamination facilities at all hospitals.

· Enhanced surge/bed capacity and alternative/mobile medical facilities.

· Improved bed status and patient-tracking reporting systems.
She expressed that was vital that the resources of the VA and DOD Systems be included in these efforts so that in the event the National Disaster Medical System is activated, the full capacity of the nation medical resources could be brought to bear.

In April 2002, The American Legion submitted testimony to this Committee in support of *H.R. 3253, National Medical Emergency Preparedness Act of 2001.*

VA possesses the infrastructure and expertise to be a significant and vital link to providing myriad services to the national efforts in preparing coordinated emergency responses. Not only did VA demonstrate their effectiveness as a first responder after 9/11; they confirmed their value through their strong research program, medical education and health professions training program and their affiliations with nearly 1,400 medical and other allied health care schools. With that type of capacity and experience in place, VA is poised to become a much bigger player in national emergency.

In November 2002, President Bush signed into law the *Department of Veterans Affairs Emergency Preparedness Act*, which called for the establishment of four medical emergency preparedness centers, staffed by VA employees and located at VA hospitals. These centers would carry out research and develop methods of detection, diagnosis, vaccination, protection, and treatment for biological, chemical or radiological attacks. Additionally, these centers would provide education, training, and advice to health-care professionals, including those outside the Veterans Health Administration (VHA); and provide contingent rapid response laboratory assistance and other assistance to local health care authorities in the event of a national emergency. It further authorized $100 million for the centers over the next five years. The American Legion fully supported these recommendations.

However, the fiscal year 2003 omnibus appropriations bill contained no provisions for establishing medical emergency preparedness centers or funding a new office within VA for operations, security and preparedness. The American Legion is outraged that the appropriators cut funding for the emergency preparedness centers at a time when we need them most.

VA cannot be expected to fulfill mandates without dedicated funding. The medical care accounts are already perpetually stretched to fulfill VA's primary mission of providing health care and services to veterans and their families. We urge this Subcommittee to support full funding needed to implement the provisions of Public Law 107-287.

Force Protection

As American military forces are once again engaged in an overseas war, the health and welfare of our deployed troops is of utmost concern to The American Legion. The need for effective coordination between VA and DOD.

Twelve years have past since the first Gulf War, many of the hazardous health conditions, apart from combat, are still major concerns in the current operations. Advancing coalition forces are encountering burning oil wells and toxic smoke, increasing the potential for respiratory illnesses. Naturally occurring virus such as anthrax and malaria are still ever present in the region. In addition to the environmental hazards are our own medical protocols to counter these health threats. Pyridostigmine Bromide (PB), a pretreatment for Soman nerve agent, has been recently approved by the FDA. Currently its use is at the commander's discretion but it has been suspect as a possible cause for the multi-symptom illness reported by thousands of 1991 Gulf War veterans. The continued use of depleted uranium munitions and the unresolved possibility of exposure contributing to further health complications are real threats to our service-members' health.

Many questions remain regarding the unexplained multi-symptom illnesses, referred to collectively as Gulf War veterans' illnesses, still plaguing thousands of Gulf War veterans. Troops in today's war will encounter many of the same hazards and agents previously identified as possible causes of these unexplained illnesses. We must be vigilant in our efforts to ensure that the mistakes made in 1991 are not repeated today.

Prior to the first Gulf War deployment, troops were not systematically given comprehensive pre-deployment health examinations, nor were they properly briefed on the potential hazards, such as fallout from depleted uranium munitions, that they might encounter on the battlefield or in the theater. Record keeping was also poor. Numerous examples of lost or destroyed medical records of active duty and reserve personnel have been identified. Vaccines were not administered in a consistent manner and vaccination records were often unclear or incomplete. Moreover, personnel were not provided information concerning vaccines or prescribed medications. Some medications were distributed with little or no documentation or dosage instructions, to include possible side effects or instructions to immediately report unexpected side effects to medical personnel.

Physical examinations, pre and post deployment, were not comprehensive and information regarding troop movements/locations and possible environmental hazard exposures was severely lacking. The lack of such baseline data and other information is commonly recognized as a major limitation in the evaluation and understanding of potential causes of Gulf War veterans' illnesses. We are doomed to repeat this pattern in this second war in Iraq if these failures are not corrected.

To avoid the procedural problems encountered both during and after the 1991 Gulf War, "lessons learned" have precipitated the enactment of legislation and policies designed to create a concept of Force Health Protection (FHP). The goal of the Department of Defense (DOD) FHP policies and programs is to promote and sustain the health of service members during their entire length of service. On the surface, the concept of Force Health Protection and related policies appear to have addressed the major problems of the past. Unfortunately, reality may be a different story. Last year, in testimony before this subcommittee, an official from the General Accounting Office (GAO) reported that although DOD placed the responsibility for implementing its FHP policies with a single authority, the Deputy Assistant Secretary of Defense for Force Health Protection and Readiness, each service branch is ultimately responsible for implementing DOD initiatives and policies to achieve FHP goals. GAO noted that this caused concerns about how the services would uniformly collect and share core data on deployments and how they will integrate information on the health status of service members. According to GAO, DOD officials also verified that DOD's medical surveillance policies and efforts depend on the priority and resources dedicated to their implementation.

The American Legion would like to specifically identify an element of Force Health Protection that deals with DOD's ability to accurately record a service member's health prior to deployment and document or evaluate any changes in their health that occurred during deployment. This is exactly the information VA needs to adequately care for and compensate service members for service-related disabilities once they leave active duty. However, DOD must do a better job of

accurately recording this information. Section 765 of PL 105-85 directed DOD to take specific actions to improve medical tracking for personnel deployed overseas in contingency or combat operations, outlining a policy for pre and post deployment health evaluations and blood samples. The conduct of a thorough "examination" (pre and post deployment), including the drawing of blood samples was specifically identified in the law.

Unfortunately, DOD's current implementation of this provision of the law does not, in our opinion, fulfill this requirement. In lieu of thorough pre and post deployment medical examinations as required by law, DOD has deploying and returning service members fill out brief health questionnaires. The pre-deployment questionnaire, DD Form 2795, contains eight questions and the post-deployment questionnaire, DD From 2796, contains six questions. A self-reported health assessment questionnaire is not of the same value as an examination conducted by a physician or other medical officer and is not an accurate gauge of an individual's health status prior to or following deployment. Thus, the law specifically requires pre and post deployment "examinations," not a simple self-reported questionnaire.

The American Legion also questions DOD's reliance on blood samples taken for human immunodeficiency virus (HIV) tests to fulfill the pre and post deployment blood drawing requirement of PL 105-85. According to DOD procedure, deploying military personnel must be tested and found negative for HIV no more than 12 months before deployment on contingency operations. Although a specimen of serum used for this testing is stored at the DOD Serum Repository, the pre-deployment sample could be up to a year old, or older, and would, therefore, not be an accurate gauge of health immediately prior to deployment. Likewise, a post-deployment HIV blood drawing may take place many months after the service member returns from deployment and would not be an accurate gauge of any changes in health that took place during deployment.

As U.S. forces move deeper into Iraq, the possibility of Iraq releasing chemical and biological weapons out of desperation increases dramatically. The American Legion is concerned about the ability of American military forces to operate and survive in a nuclear, biological or chemical (NBC) environment. During the 1991 war, the thousands of chemical detection alarms were later reported as "false alarms." The ability to properly detect the presence of NBC agents in the area of operation remains a grave concern. Questions have also recently surfaced around DOD's ability to properly identify, track and locate defective chemical protective suits. In October 2002, GAO reported that in May 2000, DOD ordered storage depots and units to locate 778,924 defective suits produced by a single manufacturer. As of July 2002, military officials were still unable to account for 250,000 defective suits. Responding to an American Legion inquiry, officials from the Deployment Health Support Directorate reported that they "believe" the remaining defective suits have either been destroyed or used in training activities. The difficulty in locating the defective suits was a result of inventory records lacking contract and lot numbers. GAO also reported that DOD could not determine whether its older suits would adequately protect military personnel because some of the systems' records do not contain data on suit expiration. Finally, GAO reported that the risk of shortages of protective clothing might increase dramatically from the time of its report (October 2002) through at least 2007.

While military service is inherently dangerous and certain risks are to be expected, the government is obligated to provide health care and compensation to those who sustain chronic disabilities as a result of such service. Title 38, United States Code places the burden of proof in establishing a service-connected disability on the veteran and establishing service connection directly impacts the veteran's ability to access VA health care. VA's ability to adequately care for and compensate our nation's veterans depends directly on DOD's efforts to maintain proper health records/health surveillance, documentation of troop locations, environmental hazard exposure data, and the timely sharing of this information with VA.

Without such information, the burden of establishing service connection and accessing entitled benefits is virtually impossible for the veteran to meet. Additionally, this information is also needed by VA to adequately complete its fourth mission of providing medical backup to DOD in times of war. If relevant health and environmental exposure information is incomplete or does not even exist due to previously discussed breakdowns in the system, discussions on how VA and DOD can better share this information is irrelevant.

Summary

The American Legion applauds Chairman Smith for the introduction of the Department of Veterans Affairs Preparedness Act of 2002 and we share the Chairman's disappointment with the appropriators' refusal to fund the provisions of this important law.

Nearly 18 months have passed since the shattering of the naïve perception that the United States is invulnerable to attack. The Armed Forces are once again fighting in a foreign land and every day they face the horrific possibility of a chemical, radiological or biological attack. In the event of any such warfare or national emergency, the nation must be prepared to respond rapidly, in a coordinated, national effort, and care for the wounded. VA must be funded at a level that will enable full and adequate fulfillment of the fourth mission.

Additionally, a sincere desire in information collection, sharing and mutual cooperation at the highest level of DOD and VA is needed in order to ensure effective force protection for U.S. servicemembers who may be exposed to chemical, biological or radiological weapons. The American Legion is heartened by a February 2003 letter from the Secretary of Veterans Affairs to the Secretary of Defense, expressing the importance of VA-DOD cooperation in collecting and sharing adequate health and exposure data from those currently deployed. This cooperation must continue if we are to provide effective protection for current and future members of the U.S. Armed Forces.

Again, I appreciate the opportunity to present testimony before the Subcommittee and The American Legion looks forward to working with each of you on these important issues. That concludes my testimony.

STATEMENT OF
ADRIAN M. ATIZADO
ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
MARCH 27, 2003

Mr. Chairman and Members of the Subcommittee:

On behalf of the 1.3 million members of the Disabled American Veterans (DAV) and its Auxiliary, we are pleased to express our views before the Subcommittee on the status of the Department of Veterans Affairs Emergency Preparedness Act of 2002, Public Law 107-287, and post-deployment health care for veterans.

The Department of Veterans Affairs (VA) Emergency Preparedness Act of 2002 authorizes VA to establish an emergency medical education program. This program is to provide health care professionals, including health care professionals outside the Veterans Health Administration to receive education, training, and advice on exposure to chemical, biological, radiological (CBR) agents, incendiary, or other explosive agents.

The Act also provides the VA Secretary with the authority to establish up to four Medical Emergency Preparedness Centers to conduct research and develop methods of detection, prevention, diagnosis, and treatment of injuries, illness and disease resulting from exposure to CBR or other explosive agents. The centers would also provide education, training, and advice to health care professionals, including health care professionals outside the Veterans Health Administration. Furthermore, in the event of a disaster or emergency, to provide medical assistance to federal, state, and local health care agencies responding to the disaster or emergency.

The Veterans Health Administration (VHA) is the nation's largest direct provider of health care services, with over 1,300 facilities, including hospitals, ambulatory care and community-based outpatient clinics, counseling centers, nursing homes, and domiciliary facilities. VA's primary mission is to provide health care to our nation's veterans. Its second mission is to provide education and training for health care personnel. VA trains approximately 85,000 health care professionals annually and is affiliated with nearly 1,400 medical and other schools. Its third mission is to conduct medical research. VA's fourth mission, defined in Public Law 97-174, the Veterans Administration and Department of Defense (DoD) Health Resources Sharing Act, enacted in 1982, provides that VA is the principal medical care backup for military health care "[d]uring and immediately following a period of war, or a period of national emergency declared by the President or the Congress that involves the use of the Armed Forces in armed conflict[.]" 38 U.S.C.A. § 8111A.

VA is an essential asset having a multitude of resources and expertise that could be utilized in Federal emergency efforts and post-deployment health. Currently, state and local agencies have the primary responsibility for managing medical response during catastrophic events. VA's role is to augment the efforts of state and local authorities should such events occur, with a supporting role as

part of the Federal Response Plan and the National Disaster Medical System. VA's Medical Emergency Radiological Response Team is trained to respond to radiological emergencies. VHA also supports the Public Health Service and Health and Human Service's office of Emergency Preparedness to ensure that adequate stockpiles of antidotes and other necessary pharmaceuticals are maintained nationwide in case of a catastrophic event such as the use of weapons of mass destruction. Additionally, VA, well known as a leading authority in treating PTSD, makes available its highly trained mental health staff to assist victims traumatized by large-scale disasters.

VA also plays a critical role in post-deployment health care for veterans. In past conflicts, veterans have experienced exposure to a variety of toxic substances during military service, prompting VA to develop a core of specialized medical programs and treatments. VA has expertise in areas such as radiation exposure, exposure to toxic chemical, biological, and environmental agents, and recently developed two new centers for the Study of War-Related Illnesses. Clearly, VA is a unique national resource, and all Americans benefit from its exceptional health-related training and research programs.

DAV was supportive of the passage of the Department of Veterans Affairs Emergency Preparedness Act of 2002; however, concerns noted in our previous testimony remain. As this Subcommittee is aware, increasing numbers of veterans are seeking care from VA, yet medical care funding has not kept pace with medical inflation and increased enrollment. This has placed significant financial stress on the VA health care system and caused longer waiting times for patient care. VA must be provided with sufficient funding to respond quickly to new threats, carry out all its missions, and correct deficiencies.

In addition, improved coordination between VA and DoD including clinical, research, and health risk communication is essential to address issues related to the health of military members, veterans and their families during and after deployment. Adverse health consequences of deployment can be minimized through coordination of interagency information management (IM) and information technology (IT) to ensure secure and complete transition of health information between VA and DoD. Lessons learned in previous conflicts reveal record keeping, the quality of pre- and post-deployment health assessments, medical surveillance during deployments, and environmental exposure assessments are integral for post deployment health care. Much has been accomplished in this area, but we believe more can be achieved.

In closing, DAV believes that VA, in its supporting role, makes a significant contribution to the emergency preparedness response activities carried out by the lead Federal agencies. We are confident that the VHA and its dedicated staff will do its utmost to meet its responsibilities to care for those who are injured in defense of our nation. We also believe that enhancing VA's role may be beneficial; however, without sufficient funding, the potential impact on VA to carry out all its health care missions is unclear. We thank the Subcommittee for holding this hearing today and providing DAV the opportunity to express our views on these two important issues.

STATEMENT OF

CARL BLAKE, ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON HEALTH

CONCERNING

THE STATUS OF IMPLEMENTATION OF P.L. 107-287,

THE "DEPARTMENT OF VETERANS AFFAIRS EMERGENCY

PREPAREDNESS ACT OF 2002"

MARCH 27, 2003

Chairman Simmons, Ranking Member Rodriguez, members of the Subcommittee, PVA would like to thank you for the opportunity to testify concerning the status of implementation of P.L. 107-287, the "Department of Veterans Affairs Emergency Preparedness Act of 2002." In light of current events taking place in the Middle East, this topic could not be more relevant.

P.L. 107-287 authorized the Secretary of Veterans Affairs (VA) to establish four emergency preparedness centers within the VA for research and development for dealing with weapons of mass destruction, to educate and train health care provisions, and to provide support to Federal, state, and local agencies. Section 3 of the law required the VA to develop and disseminate a series of model education and training programs on the medical responses to the consequences of terrorist activities. Section 4 authorized the VA to provide hospital and medical services to individuals effected by a disaster or medical emergency to include all veterans, whether enrolled in the system or not, and active duty military personnel. Finally, Section 5 established an Assistant Secretary for Operations, Preparedness, Security and Law Enforcement.

Public Law 97-174, the "Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act," currently part of 38 U.S.C. § 8111A, established the VA as the principal medical care backup for military health care "[d]uring and immediately following a period of war, or a period of national emergency declared by the President or the Congress that involves the use of the Armed Forces in armed conflict[.]" 38 U.S.C. § 8111A. This constitutes explicit statutory authority for the fourth mission of the VA. With soldiers currently in the field in combat, this mission is very much a priority at this time.

An important part of the VA's critical 4th mission is to also assist states and localities. The Government Accounting Office (GAO), in a January 2001 report entitled "Major Management Challenges and Program Risks" (GAO-01-255) characterized the VA's role as the "primary backup to other federal agencies during national emergencies." The GAO further stated, the "VA's role as part of the federal government's response for disasters has grown with the reduction of medical capacity in the Public Health Service and military medical facilities." The VA is the only health care system that is capable of providing a comprehensive and national response to the threats we face from terrorist activities and national disasters and emergencies. This important and vital role was clarified explicitly in P.L. 107-287. Under Section 4 of this act, the VA is authorized to provide medical care to anyone affected by a major disaster or national emergency. This also includes war wounded soldiers who return from the front lines of Iraq and Afghanistan.

A particular concern of PVA's is the fact that the recently enacted FY 2003 Omnibus Appropriations bill, P.L. 108-7, prohibited funding of all sections of this bill except Section 3 and 4. This effectively prevents the VA from creating the four emergency preparedness centers as well as establishing the new Assistant Secretary position. We have serious concerns with the practice of legislating through appropriations measures.

Unfortunately, amongst the growing recognition of the VA's critical role in assisting our states and localities, as well as active duty military, the Administration has failed to step forward and provide the funding necessary to accomplish this important mission, nor the leadership necessary to move forward. Last year alone, the VA estimated that it would require $250 million in the current fiscal year to begin to satisfy its 4th mission requirements. Despite not receiving funding for this mission, the VA will accomplish this mission and will therefore look to pull funding away from other programs in order to do so. This is a situation the VA should not be faced with.

PVA looks forward to working with this Subcommittee to ensure that the VA receives the resources it needs to accomplish the fourth mission as well as the resources needed to implement P.L. 107-287. At a time when we have soldiers already returning home from combat with injuries, we must be sure that the VA is ready and able to meet the needs of those brave men and women who have made, and are making, these sacrifices.

Thank you for the opportunity to testify today. I would be happy to answer any questions that you might have.

STATEMENT

of

Vietnam Veterans of America

Presented by

Richard Weidman
Director, Government Relations

Before the
House Committee on Veterans' Affairs
Subcommittee on Health

Regarding

Public Law 107-287, the Department of Veterans Affairs Emergency Preparedness Act of 2002

March 27, 2003

Vietnam Veterans of America

P.L. 107-287 the Department of Veterans Affairs Emergency Preparedness Act of 2002
March 27, 2003

Mr. Chairman, and member of the Subcommittee on Health, on behalf of Vietnam Veterans of America (VVA), and our National President Thomas H. Corey, I thank you and your distinguished colleagues for the opportunity to testify before you regarding P.L. 107-287, the Department of Veterans Affairs Emergency Preparedness Act of 2002.

Emergency Preparedness for Bio-Terrorism

Since the war on terrorism became a major focus of our National consciousness in the wake of the attacks of September 11, 2001, VVA has testified repeatedly on the need for the Department of Veterans Affairs (VA) to be properly prepared to meet the obligations of the VA's "Fourth Mission," and be prepared to handle mass casualty contingencies, particularly those involving weapons of mass destruction (WMD). This concern was widely shared, including by the Members of this Committee. In response to the clear need, Public Law 107-287 was enacted on November 7, 2002. This was a significant statement by the Congress of the need to take explicit action to be able to properly fulfill the mandate of the so-called "Fourth Mission" of the VA.

However, when Congress funded the VA for the current fiscal year, FY 2003, no funds were provided for the four national emergency preparedness centers. In fact funds appropriated were expressly forbidden to be spent on the emergency preparedness centers. This makes it very difficult, to say the least, to create an educational curriculum for medical students and professions to recognize and properly treat the wounds due to Weapons of Mass Destruction (WMD) as mandated by the Public Law 107-287, the Department of Veterans Affairs Emergency Preparedness Act of 2002. VVA asks for you strong backing of our request that $20 million be included in the FY04 VA Appropriation legislation to establish these centers as mandated by law, as these centers are critical to the Fourth Mission of the VA.

VVA understands, but respectfully disagrees with the contention of the leadership of this distinguished Committee as well as the distinguished leadership of the Subcommittee on VA, HUD, and Independent Agencies of the House Committee on Appropriations that VA should be precluded from spending funds that otherwise would go for veterans health care for this purpose.

While VVA would agree that ideally the Bioterrorism bill under the jurisdiction of the House Commerce Committee, or from appropriations for the Department of Homeland Security and/or the Department of Health & Human Services should transfer significant funds to VA for the purpose of the Fourth Mission, this appears to be unlikely in the near term.

It is worth noting that shortly after the 9/11/03 attacks, Congress gave the President $20 Billion in unfettered, and as we understand it, non-year specific money for the general purpose of "homeland security." Of these funds VA only asked for $77 million for preparation to meet the

vital "Fourth Mission" of the VA, and never even received close to that paltry (in the face of the huge mission) sum of money. VVA believes that a good part of this $20 Billion went to other agencies and departments for purposes that the ordinary taxpayer would hardly consider to be related to defending our Nation here at home.

Frankly, the health of the civilian population in the wake of any potential attack should be a major concern of the President and his Administration. However, unless we missed it, this Administration has not sought any such funds to build the needed organizational capacity at the VA medical facilities. If the President asked for such funds, it would be available, no matter what the amount requested, by the end of next week if that is when he said he needed the funds. We are at war, yet too much seems to be proceeding on a business as usual basis in too many areas of potential real vulnerabilities.

While we believe that Mr. Walsh and his colleagues, as well as the leadership of this Committee, are correct on a conceptual level, it is vital to the American people the centers to move forward. One good way to solve this dispute would be to properly fund VA health care by enacting legislation that would create mandatory funding that would provide the full funding of $35 billion that the veterans health care system should have this year, had funding kept pace with inflation and per capita increases since 1996. You will note that there is a graph visually portraying this fact in Appendixes I-II of this statement. There is further elucidation of the problems with funding in the VVA Statement to this Committee delivered last Thursday, March 20, 2003, that is posted on this Committees' web site.

Insufficient Infrastructure

The VA health care centers today do not have sufficient infrastructure to properly meet the demands of major attacks on the United States. While there have been some nascent efforts toward training VA staff in how to recognize and deal with possible modes of terrorist attacks, VVA would point out that we cannot even get VA to take a proper military history for veterans seeking medical services, which should be the common sense first step in a system ostensibly geared toward identifying, addressing, and properly treating the wounds of war.

VVA was informed by VA Environmental Hazards & Public Health staff at the Veterans Health Administration that there is no expert in treating biological or chemical warfare agents at each of the VA medical centers around the country, not even in an "on call" or consultant capacity. We are also given to understand that there is no ongoing effort to train staff physicians in how to treat these types of WMD wounds, much less the part time physicians and the residents and interns who form much of the overall medical capacity of the VA. Even more disturbing is the surprise that greets questions about why this is not being done.

It should be no secret to any Member on this distinguished panel, nor anyone in attendance, that VA cannot take care of the veterans who are seeking services now, in most sections of the country. VA medical center inpatient capacity has been most dramatically reduced, to far less than half of the capacity at the end of Gulf War I back in 1991. The veterans healthcare system is so overwhelmed and so short of vitally needed resources that Secretary Principi has been forced into doing triage by means of taking the extraordinary step of temporarily suspending new enrollments by what are now called "Category 8" veterans until such time as there is enough money provided to hire enough staff to care for all veterans in need of health care services. In 1996, VA had significantly more inpatient beds (meaning not only the physical beds, but more importantly the trained medical professionals that comprise the teams to serve patients in those beds), than today. You only have to look at the graphs in Appendixes III-IV to realize that the nursing and doctor staff are not there to meet all of the demands now, never mind the returning troops who may be in such need and the civilians who may be wounded or ill as a result of terrorist attacks in the United States.

In light of all of the above, VVA top leaders and key staff were puzzled at the assertion by Deputy Secretary of Veterans Affairs McKay in the Washington Post of 3/25/03 that VA will make as many as 7,000 beds available to the Department of Defense for returning service personnel who are wounded and cannot be seen by overloaded military medical facilities. VVA is certainly interested in exactly where these beds are located, given the dramatic reductions in force and degrading of organizational capacity of the Veterans Health Administration (VHA) during the past decade.

Veterans Health Initiative (VHI)

Veterans Health Initiative (VHI) was started in 1999 to accomplish two primary goals, each of which had specific objectives. The Task Force was initiated and named by Dr. Thomas Garthwaite, then Undersecretary of Veterans for Health. There was a task group that was supposed to come up with recommendations and actual curricula about the primary special wounds and illnesses due to the very dangerous occupation that all veterans were engaged in at one time, whether it was two years or twenty five years. Additionally this group was supposed to cooperate with the other subgroup and develop a plan and short curriculum for all VA staff in who are veterans, and what is special about veterans health care as opposed to general health care that happens to be for veterans. That second subgroup, Co-Chaired by Dr. Arthur Shelton (Col, USA-Retired) and Dr. Alfonse Batres, was supposed to guide creation of an appropriate military history for each veteran that comes to the VA for health care. That subgroup included representatives from The American Legion, Vietnam Veterans of America (VVA), and from the Department of Defense (DoD) as well as VA people.

The curricula that were produced are the first ever of this kind, and may be viewed at www.va.gov/vhi. While VVA would like to see improvements in a number of the curricula, the mere fact that they exist is a very positive step. However, very few at VA know of the existence of these curricula. While the original discussion was for financial incentives provided to those who studied the curricula and passed a rigorous competency based exam, rewarding staff with the "coin of the realm" has gone by the wayside. Now one may use the curricula for continuing education credits only. The "exam" has a 100% pass rate.

Much of the work to create a complete military history as a mandatory screen on the automated patient treatment record (PTR) at VHA was done. The goals were to produce a seamless transition of military records and military medical records to a VA computer repository as well as to the Records Center at St. Louis when a person separates from the military. Additionally, there would be a complete military history taken for those already separated from the military.

There was much discussion and general agreement of an additional need to train all clinical staff as to the importance of the military history, testing for illnesses, injuries, maladies, and other conditions (e.g., parasites that can lay dormant for up to fifty years) that veterans might have been potentially exposed to in military service depending on branch, dates of service, duty stations, military occupation, and what actually happened to the former service member. Lastly, there was general assent to the need for training for all VA staff, including clerical and housekeeping as to who are veterans, and what is the mission of the VA. There was even a training film potentially designated for use in such a broad scale effort to move VA toward its central mission of being an effective veterans health care system.

All of these efforts slowed when the Senate forced a dilution in the requirement to take a complete military history from a mandate to a "sense of the Congress." After Dr. Garthwaite left all visible efforts to move ahead with taking a military history virtually ceased. Even the proposed training film was lost for several months, and by the time it was located (in response to persistent inquiries from VVA) the soundtrack had changed and certain copyright permissions had been allowed to expire.

VVA urges this Committee and your distinguished counterparts on the Senate side to require that VA create such a mandatory military screen as an integral part of the PTR and have it fully operational within the year. (The beta testing of a preliminary version of the system was done last year.) We also strongly urge that the Congress require that the capability to do nationwide searches regularly based on disease, condition, or duty station be an integral part of this system. If VA says that this cannot be done, then get some manager in there who will get it done. Suspending all step promotions and bonuses and promotions until it go done would mean design and full implementation in weeks or a few short months instead of years. With this capability,

VA could easily be able to discern patterns related to particular duties, particular location, or other variables that would provide clues as to fruitful avenues and areas needing focused research. It can be done in short order with the proper will to do it.

Pre-Deployment & Post-Deployment Physicals

Although required by law to take pre-deployment physicals for all troops prior to deployment, including blood samples to be preserved, and a complete psycho-social examination the Department of Defense (DoD) has deliberately failed to obey the law. The law, a copy of which is attached to this statement as Appendix V, is very clear on what is required. VVA points out that this is the law, and not a suggestion. All of the people involved at DoD took the public officers oath, wherein they swore to uphold the laws of the United States of America. It would seem to a layman that these individuals, by ignoring the law, have violated their oath of public office. At some point this treating of laws by some elements of the Federal bureaucracy as cute ideas advanced by the Congress must be brought to account. This is true at both the VA as well as DoD.

The Assistant Secretary of Defense for Health Affairs and the Deployment Force safety Directorate have simply not done what is required by the law, and which common sense would dictate in light of the experiences of the past. Instead of fulfilling the intent of the law and ensuring that a "baseline" for every deployed service member is taken, great effort seems to be expended on trying to convince the media and the Congress that laughable questionnaires utterly useless from a scientific epidemiological viewpoint is somehow meeting the clear mandates of the law. This reminds one of the F. Scott Fitzgerald quote, "Let's not and say we did!"

Said another way, as one VVA leader put it, "If these people had spent as much time and effort on medical work that would be useful in the future as they have on courting the press and "SPIN" efforts, then our troops would be in good hands." Unfortunately that does not appear to be the case.

This is not a new issue, as VVA and others have been attempting to get these physicals and blood samples taken properly for more than a year for those military personnel deployed into harms way. We even spoke directly to Secretary of Defense Rumsfeld in May of 2002. An assistant to Dr. Winkenwerder who was present noted that it was a big job, as the force was large. The response from VVA was that we understand that it is a large force, but that is their job. Does the fact that it is a large force mean that they will not be able to get sufficient ammunition to all of our forces when they need it?

While one must be careful of drawing parallels too easily, it is at least worth noting that this office that failed to ensure the required creation of a medical baseline for each person deployed is the same office that has in the past few years been recalcitrant to say the least in regard to providing information regarding Project 112 and the subsidiary experiments know as "SHAD" or "Shipboard Hazards And Decontamination." The actions regarding release of information regarding earlier exposures do not foster confidence or credibility that this operation is really concerned about the health of individuals who may have been harmed. As an example, there has been no access granted to any researcher to the blood serum repository located in Rockville, Maryland that DoD claims meets the requirement in regard to the blood sample. DoD knows, as does VA that there are tests for some of the potential harmful agents that can be applied to whole blood that cannot be applied to blood serum, yet they maintain that this is all that is needed.

What To Do Now

VVA would recommend that the Congress take several steps at this late date:

One, that you and your distinguished colleagues on the Armed Services Committee work directly with Secretary Rumsfeld to ensure that a system is put in place immediately that would ensure compliance with the pre-deployment physicals.

Two, that the Congress ensure that proper full physicals, including a complete psycho-social exam and significant blood samples be taken in post deployment physicals on every returning service member.

Three, that Congress look into potential studies that have not been done in the past on existing samples that can be done for Gulf War I veterans, as well as for Gulf War II veterans.

Four, that VA "Fourth Mission" be properly funded, whatever the method of channeling funds to this purpose.

Five, that the War Related Injury and Illness Study Center (WRIISC) be greatly expanded and have a role in the implementation of military history for every veteran seeking medical help at VA. Further, VVA recommends that these centers be expanded, publicized, and much more closely linked with VA entities such as the Centers of Excellence in SCI, hepatitis C, and the National Center for Post Traumatic Stress Recovery.

Mr. Chairman, that concludes our statement. I would be pleased to answer any questions you may have.

VIETNAM VETERANS OF AMERICA
Funding Statement

March 27, 2003

A national organization, Vietnam Veterans of America (VVA) is a non-profit veterans membership organization registered as a 501(c)(19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true for the previous two fiscal years.

For Further Information, contact:
Director of Government Relations
Vietnam Veterans of America
(301) 585-4000 ext 127

Vietnam Veterans of America

P.L. 107-287 the Department of Veterans Affairs Emergency Preparedness Act of 2002
March 27, 2003

Richard F. Weidman

Rick Weidman serves as Director of Government Relations of Vietnam Veterans of America. As such, he is the primary spokesperson for VVA in Washington. He served as a 1-A-O Army Medical Corpsman during the Vietnam War, including service with Company C, 23rd Med, AMERICAL Division, located in I Corps of Vietnam in 1969.

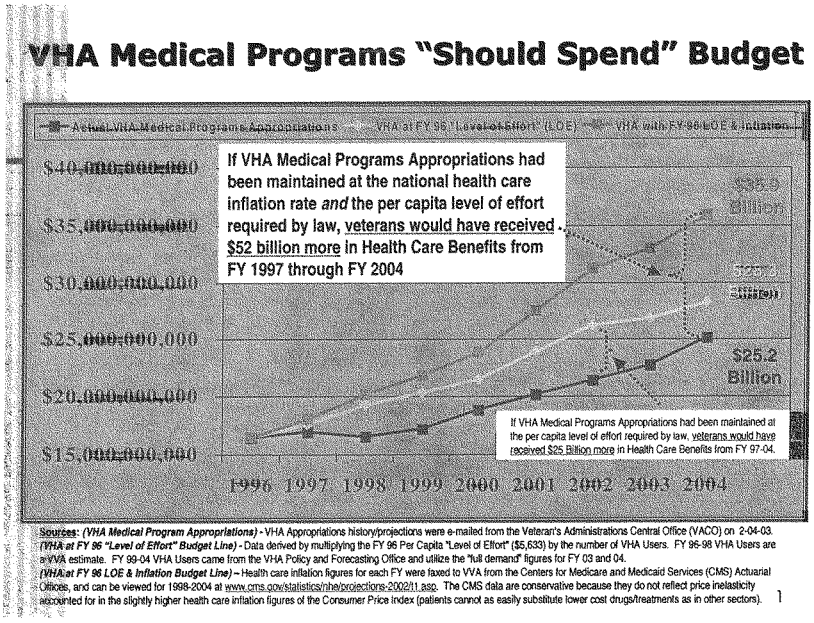
Weidman was part of the staff of VVA from 1979-1987, serving variously as Membership Director, Agency Liaison, and Director of Government Relations. He left VVA to serve in the Administration of New York Governor Mario M. Cuomo as statewide director of Veterans Employment & Training (State Veterans Programs Administrator) for the New York State Department of Labor.

He has served as consultant on legislative affairs to the National Coalition for Homeless Veterans and served at various times on the VA Readjustment Advisory Committee, the Secretary of Labor's Advisory Committee on Veterans Employment & Training, the President's Committee on Employment of Persons with Disabilities Subcommittee on Disabled Veterans, the Advisory Committee on Veterans' Entrepreneurship at the Small Business Administration, and numerous other advocacy posts in veterans affairs. Among his other responsibilities, he is currently serving as Chairman of the Task Force for Veterans' Entrepreneurship and the Task Force for Veterans Preference & Government Accountability, both of which are mechanisms for veterans organizations and other Americans committed to justice for veterans to coordinate efforts on these vital issues.

Weidman was an instructor and administrator at Johnson State College (Vermont) in the 1970s, where he also was active in community and veterans affairs. He attended Colgate University, from which he received his bachelor of arts degree in 1967, and did graduate study at the University of Vermont.

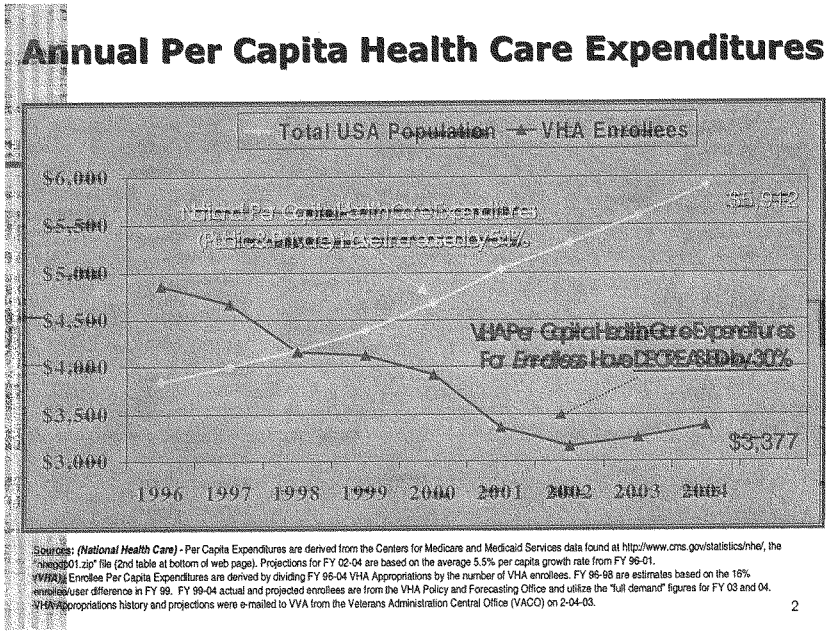
He is married and has four children.

Appendix I



Sources: ***(VHA Medical Program Appropriations)*** - VHA Appropriations history/projections were e-mailed from the Veteran's Administrations Central Office (VACO) on 2-04-03. ***(VHA at FY 96 "Level of Effort" Budget Line)*** - Data derived by multiplying the FY 96 Per Capita "Level of Effort" ($5,633) by the number of VHA Users. FY 96-98 VHA Users are a VVA estimate. FY 99-04 VHA Users came from the VHA Policy and Forecasting Office and utilize the "full demand" figures for FY 03 and 04. ***(VHA at FY 96 LOE & Inflation Budget Line)*** – Health care inflation figures for each FY were faxed to VVA from the Centers for Medicare and Medicaid Services (CMS) Actuarial Offices, and can be viewed for 1998-2004 at www.cms.gov/statistics/nhe/projections-2002/t1.asp. The CMS data are conservative because they do not reflect price inelasticity accounted for in the slightly higher health care inflation figures of the Consumer Price Index (patients cannot as easily substitute lower cost drugs/treatments as in other sectors).

Appendix II

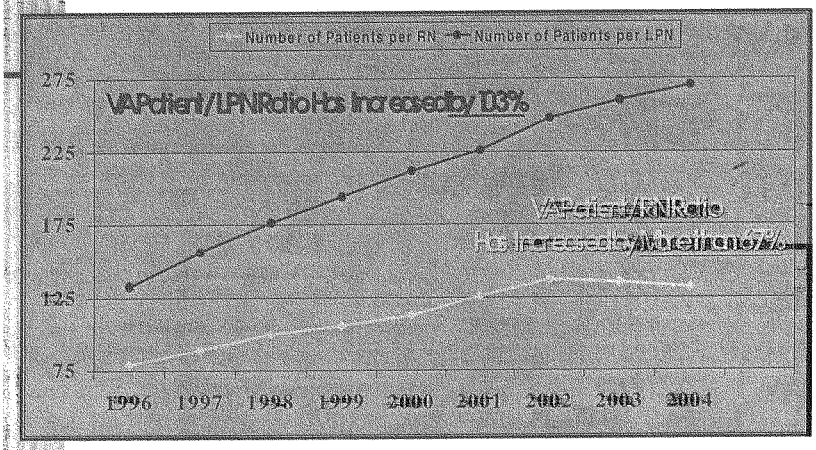


Sources: ***(National Health Care)*** - Per Capita Expenditures are derived from the Centers for Medicare and Medicaid Services data found at http://www.cms.gov/statistics/nhe/, the "nhegdp01.zip" file (2nd table at bottom of web page). Projections for FY 02-04 are based on the average 5.5% per capita growth rate from FY 96-01.
(VHA) - Enrollee Per Capita Expenditures are derived by dividing FY 96-04 VHA Appropriations by the number of VHA enrollees. FY 96-98 are estimates based on the 16% enrollee/user difference in FY 99. FY 99-04 actual and projected enrollees are from the VHA Policy and Forecasting Office and utilize the "full demand" figures for FY 03 and 04. VHA Appropriations history and projections were e-mailed to VVA from the Veterans Administration Central Office (VACO) on 2-04-03.

2

Appendix III

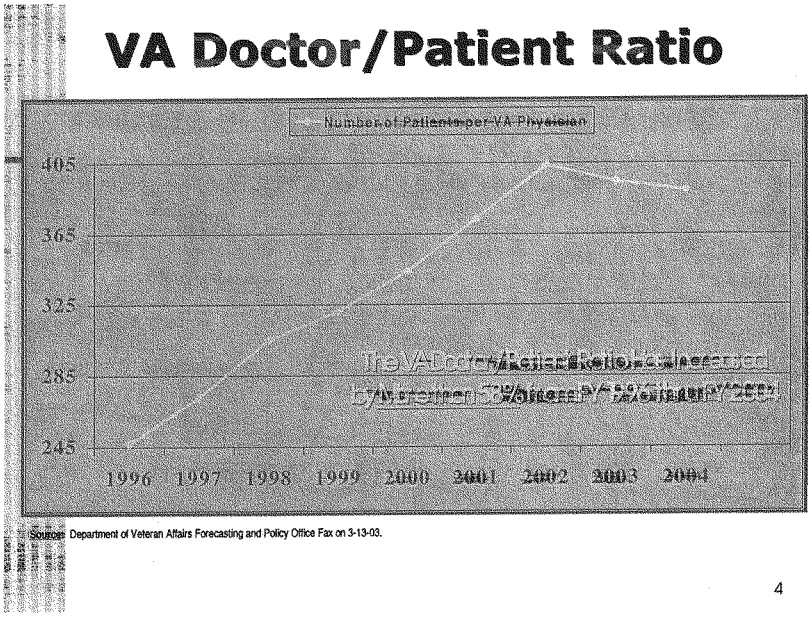
VA Nurse/Patient Ratio



Source: Department of Veteran Affairs Forecasting and Policy Office Fax on 3-13-03.

3

Appendix IV


VA Doctor/Patient Ratio
Number of Patients per VA Physician
405
365
325
285
245
1996
1997
1998
1999
2000
2001
2002
2003
2004
Source: Department of Veteran Affairs Forecasting and Policy Office Fax on 3-13-03.
4

Appendix V

National Defense Authorization Act for Fiscal Year 1998''. Year 1998.
PUBLIC LAW 105–85—NOV. 18, 1997

SEC. 764. MEDICAL CARE FOR CERTAIN RESERVES WHO SERVED IN SOUTHWEST ASIA DURING THE PERSIAN GULF WAR.

(a) IN GENERAL.—Chapter 55 of title 10, United States Code, is amended by inserting after section 1074d the following new section:

''§ 1074e. Medical care: certain Reserves who served in Southwest Asia during the Persian Gulf Conflict

''(a) ENTITLEMENT TO MEDICAL CARE.—A member of the armed forces described in subsection (b) is entitled to medical care for a qualifying Persian Gulf symptom or illness to the same extent and under the same conditions (other than the requirement that the member be on active duty) as a member of a uniformed service who is entitled to such care under section 1074(a) of this title.

''(b) COVERED MEMBERS.—Subsection (a) applies to a member of a reserve component who—

''(1) is a Persian Gulf veteran;
''(2) has a qualifying Persian Gulf symptom or illness;
and
''(3) is not otherwise entitled to medical care for such symptom or illness under this chapter and is not otherwise eligible for hospital care and medical services for such symptom or illness under section 1710 of title 38.
''(c) DEFINITIONS.—In this section:
''(1) The term 'Persian Gulf veteran' means a member of the armed forces who served on active duty in the Southwest Asia theater of operations during the Persian Gulf Conflict.
''(2) The term 'qualifying Persian Gulf symptom or illness' means, with respect to a member described in subsection (b), a symptom or illness—
''(A) that the member registered before September 1, 1997, in the Comprehensive Clinical Evaluation Program of the Department of Defense and that is presumed under section 721(d) of the National Defense Authorization Act for Fiscal Year 1995 (10 U.S.C. 1074 note) to be a result of service in the Southwest Asia theater of operations during the Persian Gulf Conflict; or ''(B) that the member registered before September 1, 1997, in the Persian Gulf War Veterans Health

Registry maintained by the Department of Veterans Affairs pursuant to section 702 of the Persian Gulf War Veterans' Health Status Act (38 U.S.C. 527 note).''.
(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1074d the following new item:

''1074e. Medical care: certain Reserves who served in Southwest Asia during the Persian Gulf Conflict.''.

SEC. 765. IMPROVED MEDICAL TRACKING SYSTEM FOR MEMBERS DEPLOYED OVERSEAS IN CONTINGENCY OR COMBAT OPERATIONS.
(a) SYSTEM REQUIRED.—(1) Chapter 55 of title 10, United States Code, is amended by inserting after section 1074e (as added by section 764) the following new section:
''§ 1074f. Medical tracking system for members deployed overseas
''(a) SYSTEM REQUIRED.—The Secretary of Defense shall establish a system to assess the medical condition of members of the armed forces (including members of the reserve components) who are deployed outside the United States or its territories or possessions as part of a contingency operation (including a humanitarian operation, peacekeeping operation, or similar operation) or combat operation.
''(b) ELEMENTS OF SYSTEM.—The system described in subsection (a) shall include the use of predeployment medical examinations and postdeployment medical examinations (including an assessment of mental health and the drawing of blood samples) to accurately record the medical condition of members before their deployment and any changes in their medical condition during the course of their deployment. The postdeployment examination shall be conducted when the member is redeployed or otherwise leaves an area in which the system is in operation (or as soon as possible thereafter).
''(c) RECORDKEEPING.—The results of all medical examinations conducted under the system, records of all health care services (including immunizations) received by members described in subsection (a) in anticipation of their deployment or during the course of their deployment, and records of events occurring in the deployment area that may affect the health of such members shall be retained and maintained in a centralized location to improve future access to the records.
''(d) QUALITY ASSURANCE.—The Secretary of Defense shall establish a quality assurance program to evaluate the success of the system in ensuring that members described in subsection (a) receive predeployment medical examinations and postdeployment medical examinations and that the recordkeeping requirements with respect to the system are met.''.

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1074e (as added by section 764) the following new item:

''1074f. Medical tracking system for members deployed overseas.''.
(b) REPORT.—Not later than March 1, 1998, the Secretary of
Defense shall submit to Congress an analysis of the administrative implications of establishing and administering the medical tracking system required by section 1074f of title 10, United States Code,
as added by subsection (a). The report shall include, for fiscal year 1999 and the 5 successive fiscal years, a separate analysis and specification of the projected costs and operational considerations
for each of the following required aspects of the system:
(1) Predeployment medical examinations.
(2) Postdeployment medical examinations.
(3) Recordkeeping.

House Committee on Veteran's Affairs
Subcommittee on Health
March 27, 2003
Testimony of John D. Shanley, M.D.
University of Connecticut Health Center

Good Morning and thank you, Mr. Chairman, for the opportunity to testify before the House Committee on Veteran Affairs, Subcommittee on Health regarding the Public Law 107-287, The Department of Veteran Affairs Emergency Preparedness Act of 2002.

I'd like to introduce myself – I am Dr. John D. Shanley, Professor of Medicine and Director of the Division of Infectious Diseases at the University of Connecticut Health Center in Farmington, CT and the Connecticut State Chair in Infectious Diseases and AIDS.

I have a long-standing relationship with the Veterans Administration. When I initially came to the University of Connecticut in 1982, my laboratory and offices were at the Newington Veterans Hospital, although I shared a joint appointment with the University of Connecticut. I have, in the past, had Career Development Awards for my research and served on the Merit Review Panels for the Department of Veteran's Affairs research program. I was also the Director of the Infectious Disease Program at the Newington VA Medical Center before moving to Farmington to become Director of Infectious Disease at the University Hospital.

I have also had a long-standing interest in the areas of biological warfare and terrorism and for two years was a member of the Infectious Disease Society of American Subcommittee on Bioterrorism. At the present time, I am part of the Smallpox Preparedness Program Phase 1 at the University of Connecticut and the Connecticut State Department of Public Health and am a member of the Vaccine Adverse Events Committee.

We have entered an era in our nation's history where the things that were previously unthinkable have become reality. Witness 9/11 and the events involving the use of anthrax in 2002. Thus, it is essential that this nation be prepare for the potential future use of agents of mass destruction.

The biological and chemical agents chosen for these kinds of acts have a number of important characteristics that have to be recognized for us to do our planning. As a group, these agents share a number of common characteristics. They are generally that can be delivered by aerosol transmission. They have to have a highly susceptible population, either military or civilian. The agents must be able to inflict a high rate of morbidity or mortality or otherwise paralyze the political and economic structure of the target. Finally, they must be initially difficult to diagnose and treat.

There are important differences among the agents that also need to be recognized for planning. Agents such as anthrax, toxins and gases will present themselves in a much different manner than some of the infectious agents. In general, they will behave more like a conventional weapon with a large-scale event effecting a large number of people at once. They do not transmit themselves after their initial exposure and the response will generally be something that would be amenable to handling by conventional first responders such as the police, fire department and biohazard teams.

Infectious agents such as smallpox are more likely to present in a very different manner. Recognizing this is extremely important in planning. Initially, these would generally present as sporadic cases that would not necessarily initially be recognized for what they are. There is person to person transmission which means they would initiate a rolling epidemic until effective containment could be put in place. In general, as they popped up in scattered areas they would initially be difficult to recognize until the magnitude of the event was recognized.

There are a number of examples the have occurred that provide us with insight as to how these events might develop and the potential magnitude that they may ultimately reach. . Although not thought to be a bioterrorist event, we can currently look at the spread of Severe Acute Respiratory Syndrome (SARS) that emerged in Asia and is now affecting the world. This highly contagious agent is a good example of what might occur with the release of an infectious agent and provides an indication of how difficult it is to contain such agents. History also contains important models from which we can learn. The best example is the flu pandemic of 1918 which

claimed more lives than both WWI and WWII and swamped the health deliver systems of that time.

All of these agents, whether infectious, gas or toxins or nuclear, all have the capacity to rapidly overwhelmed the current domestic health care system. In the winter of 2000, an epidemic of influenza in California rapidly overwhelmed the hospital capacity in the city of Los Angeles. Although this was an abnormally heavy year for influenza, it was not pandemic influenza and was not an event that would match the problems of a biological attack. This is why I feel the implementation of Public Law 107-287 is so important. This law will put in place an infrastructure that will allow responses to such potentially devastating events.

The VA has a long-standing role in clinical care, research and education and has an extensive infrastructure throughout the United States. Although its infrastructure has been somewhat weakened by diminished resources over the last 10 years, its staff and facilities are ideal to provide a platform for the implemention of Public Law 107-287. The establishment of regional centers to deal with bioterrorism is critical. This will form the basis for education of the medical community in the recognition and treatment of biological, chemical and nuclear events. It will also provide a platform for research of these agents in concert with state and federal public health agencies and with military agencies such as USAMRIID. It will provide a source for research and the development of diagnostics that are otherwise somewhat scattered at the present time.

Finally, in the event of a biological episode, this infrastructure can provide the treatment centers that will be needed to deal with the potential mass casualties that would otherwise overwhelm the civilian health care system. I feel that this legislation has far-reaching implications and I feel it is essential that it be implemented as expediently as possible.

Thank you for the chance to testify before the Committee and if I can answer any questions, I would be delighted.

PREPARED TESTIMONY
OF

LAWRENCE A. FELDMAN, PH.D.
VICE PRESIDENT
UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH

MARCH 27, 2003
334 CANNON HOUSE OFFICE BUILDING
10:00 A.M.

MR. CHAIRMAN AND HONORABLE MEMBERS OF THIS COMMITTEE, I AM LAWRENCE A. FELDMAN, PH.D., VICE PRESIDENT OF THE UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY.

THE UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY (UMDNJ) IS THE LARGEST FREESTANDING PUBLIC UNIVERSITY OF THE HEALTH SCIENCES IN THE NATION. THE UNIVERSITY IS LOCATED ON FIVE STATEWIDE CAMPUSES AND CONTAINS THREE MEDICAL SCHOOLS, AND SCHOOLS OF DENTISTRY, NURSING, HEALTH RELATED PROFESSIONS, PUBLIC HEALTH AND GRADUATE BIOMEDICAL SCIENCES. UMDNJ COMPRISES A UNIVERSITY-OWNED ACUTE CARE HOSPITAL, THREE CORE TEACHING HOSPITALS, AN INTEGRATED BEHAVIORAL HEALTH CARE DELIVERY SYSTEM, A STATEWIDE SYSTEM FOR MANAGED CARE AND AFFILIATIONS WITH MORE THAN 200 HEALTH CARE AND EDUCATIONAL INSTITUTIONS STATEWIDE.

WE CONGRATULATE CHAIRMAN CHRIS SMITH AND THIS COMMITTEE FOR SECURING THE PASSAGE OF PUBLIC LAW 107-287, THE DEPARTMENT OF VETERANS AFFAIRS EMERGENCY PREPAREDNESS ACT OF 2002. THIS

LEGISLATION RECOGNIZES OUR NATION'S CONTINUED VULNERABILITY TO BIOLOGICAL, CHEMICAL OR RADIOLOGICAL ATTACK AND THE UNIQUE RESOURCES THAT EXIST WITHIN THE VETERANS ADMINISTRATION AND OUR NATION'S MEDICAL AND HEALTH PROFESSIONS SCHOOLS TO BETTER PREPARE FOR THESE CONTINGENCIES.

TODAY AS OUR NATION COMMITS ITS MILITARY FORCES TO DEFEND FREEDOM IN IRAQ, OUR BRAVE SOLDIERS LAY EXPOSED TO THE POTENTIAL OF BIOLOGICAL OR CHEMICAL ATTACK. ONCE RETURNED HOME, OUR VETERANS ADMINISTRATION HOSPITALS WILL BE CALLED UPON TO PROVIDE THE CARE NEEDED TO RETURN OUR VETERANS TO PRODUCTIVE LIVES.

THE NEW STATUTE RECOGNIZES THAT MANY DISEASES AND TOXINS THAT TERRORISTS MIGHT USE ARE NOT SEEN IN THE NORMAL COURSE OF CIVILIAN MEDICAL PRACTICE, AND ONLY RARELY IN THE MILITARY ENVIRONMENT.

REGIONAL PREPAREDNESS CENTERS CREATED UNDER THE NEW LAW JOINS THE RESOURCES OF VA MEDICAL CENTERS WITH SCHOOLS OF MEDICINE, PUBLIC HEALTH, ALLIED HEALTH AND NURSING TO WORK COOPERATIVELY IN DEVELOPING RESEARCH AND EDUCATION PROGRAMS TO RESPOND TO TERRORIST AND OTHER PUBLIC HEALTH THREATS. THE DESIGNATED PREPAREDNESS CENTERS WOULD PROVIDE TRAINING TO VA STAFF, COMMUNITY PHYSICIANS, AND OTHER HEALTH CARE PROFESSIONALS IN THE DIAGNOSIS AND TREATMENT OF INJURIES OR ILLNESSES INDUCED BY EXPOSURES TO CHEMICAL AND BIOLOGICAL SUBSTANCES, RADIATION, AND INCENDIARY OR OTHER EXPLOSIVE WEAPONS OR DEVICES. IN THIS WAY THE VA EMERGENCY PREPAREDNESS ACT LEVERAGES THE STRONG AFFILIATIONS THAT EXIST

BETWEEN VA MEDICAL CENTERS AND MANY OF OUR NATION'S SCHOOLS OF MEDICINE. FOR EXAMPLE, THE VA NEW JERSEY HEALTH CARE SYSTEM IS A MAJOR TRAINING SITE FOR UMDNJ STUDENTS AND GRADUATES. MEDICAL STUDENTS AND RESIDENTS, AS WELL AS MEDICAL, NURSING AND ALLIED HEALTH UNDERGRADUATES PARTICIPATE IN CLINICAL ROTATIONS AND CLERKSHIPS WITHIN THE LYONS AND EAST ORANGE VA FACILITIES TO ENHANCE THEIR CLINICAL SKILLS AND KNOWLEDGE WHILE DELIVERING HEALTH SERVICES TO VETERANS.

THE TRAINING OF PHYSICIANS AND OTHER HEALTH CARE PROFESSIONALS IN THE DIAGNOSIS AND TREATMENT OF ILLNESSES CAUSED BY EXPOSURE TO BIOLOGICAL AND CHEMICAL SUBSTANCES, AS PROVIDED IN THE NEW STATUTE, IS AN INTEGRAL, NATURAL AND CRITICAL EXPANSION OF THE MISSION OF THE NATION'S HEALTH PROFESSIONS SCHOOLS. UMDNJ- NEW JERSEY MEDICAL SCHOOL HAS PROVIDED TRAINING IN BIOTERRORISM RELATED ISSUES TO ITS GRADUATE STUDENTS FOR SEVERAL YEARS. UMDNJ AND RUTGERS UNIVERSITY JOINTLY SPONSOR A NATIONAL INSTITUTES OF HEALTH (NIH)/NATIONAL INSTITUTE OF ENVIRONMENTAL HEALTH SCIENCE NATIONAL CENTER OF EXCELLENCE, THE ENVIRONMENTAL AND OCCUPATIONAL HEALTH SCIENCES INSTITUTE (EOHSI), CONSIDERED TO BE ONE OF THE NATION'S FOREMOST PROGRAMS IN EDUCATION AND TRAINING CONCERNING CHEMICAL AND OTHER ENVIRONMENTAL THREATS. FACULTY AT EOHSI ARE ALREADY WORKING CLOSELY WITH THE VA TO DEVELOP EDUCATIONAL MODULES ON EXPOSURE-RELATED CHRONIC ILLNESSES. THE CREATION OF REGIONAL VA PREPAREDNESS CENTERS COULD EFFECTIVELY LEVERAGE THESE EXISTING RESOURCES TO ENHANCE THE EDUCATION AND PREPAREDNESS OF OUR NATION'S MEDICAL AND PUBLIC HEALTH COMMUNITIES.

REGIONAL VA PREPAREDNESS CENTERS WOULD ALSO BE CALLED UPON TO INCREASE OUR NATION'S CAPACITY FOR CARRYING OUT RESEARCH ON THE DETECTION, DIAGNOSIS, PREVENTION AND TREATMENT OF INJURIES AND ILLNESSES RELATED TO EXPOSURE TO CHEMICAL, BIOLOGICAL OR RADIOLOGICAL TOXINS. THESE CENTERS WOULD ENGAGE IN DIRECT RESEARCH AND COORDINATE THEIR ACTIVITIES WITH AFFILIATED SCHOOLS OF MEDICINE, SCHOOLS OF PUBLIC HEALTH, AND OTHER PUBLIC AND PRIVATE AGENCIES TO LEVERAGE EXISTING RESOURCES AND ACTIVITIES.

FOR EXAMPLE, AS THE STATE'S ONLY ACADEMIC HEALTH CENTER, UMDNJ OFFERS AN INTEGRATED NETWORK OF BASIC AND APPLIED RESEARCH THAT ADDRESSES THE HEALTH IMPLICATIONS OF EXPOSURE TO BIOLOGICAL AND CHEMICAL WEAPONRY. AT ITS BIOSAFETY LEVEL 3 LABORATORY, THE UMDNJ CENTER FOR BIODEFENSE IS CONDUCTING RESEARCH TO BETTER UNDERSTAND THE HUMAN IMMUNE RESPONSE TO INFECTION BY A WIDE RANGE OF AGENTS.

AS ONE OF TWO WAR-RELATED ILLNESS AND INJURY STUDY CENTERS CREATED BY THE VA, THE EAST ORANGE CAMPUS OF THE VETERANS ADMINISTRATION NEW JERSEY HEALTH CARE SYSTEM IS COLLABORATING WITH UMDNJ TO INCREASE THE UNDERSTANDING OF THE MEDICALLY UNEXPLAINED SYMPTOMS OF VETERANS DEPLOYED TO COMBAT AREAS. UMDNJ AND VA COLLABORATIONS EXTEND TO MANY OTHER AREAS, INCLUDNG THE MEDICAL CONSEQUENCES OF STRESS.

UMDNJ AND THE VA NEW JERSEY HEALTH CARE SYSTEM ENJOY MANY OTHER CLOSE AFFILIATIONS IN RESEARCH, EDUCATION AND HEALTH CARE THAT WOULD PROVIDE CRITICAL SUPPORT IN MEETING THE

OBJECTIVES OF THE STATUTE TO ENHANCE OUR NATION'S PREPARDEDNESS.

WE CONGRATULATE THE FULL COMMITTEE CHAIRMAN IN SECURING $20 MILLION IN BUDGET AUTHORITY WITHIN THE VETERANS PORTION OF THE HOUSE BUDGET RESOLUTION, PROVIDING SUFFICIENT BUDGET ALLOWANCE FOR FIRST YEAR FUNDING TO ESTABLISH FOUR NATIONAL EMERGENCY PREPAREDNESS CENTERS. WE URGE THE CONGRESS TO COMPLETE THIS JOB AND PROVIDE THE NECESSARY SUPPORT FOR THE FULL IMPLEMENTATION OF PUBLIC LAW 107-287. THE TIME TO ENHANCE OUR NATION'S PREPAREDNESS FOR BIOLOGICAL AND CHEMICAL ATTACK IS NOW AND THE VA, TOGETHER WITH AFFILIATED SCHOOLS OF MEDICINE, OFFERS SIGNIFICANT RESOURCES AND ASSETS TO MEET THESE OBJECTIVES.

THANK YOU FOR THIS OPPORTUNITY TO APPEAR BEFORE THE COMMITTEE.

Testimony of Harold L. Timboe, MD, MPH
Associate Vice President for Administration
University of Texas Health Science Center at Houston

Mr. Chairman, Members, I appreciate the opportunity to address the Committee in support of implementing the Department of Veterans Affairs Emergency Preparedness Act of 2002. Also, on behalf of President Francisco Cigarroa, I want to thank Congressman Ciro Rodriguez for his leadership in passing this law.

I am Dr. Harold Timboe, Director, Center for Public Health Preparedness and Biomedical Research at The University of Texas Health Science Center at San Antonio. Today, I am representing Dr. Francisco Cigarroa, President of The University of Texas Health Science Center and a member of Secretary Tommy Thompson's National Advisory Council on Public Health Preparedness. The health science university that I represent is one of the largest and most comprehensive health science universities in the country, educating the next generation of professional health care teams. We have three campuses in San Antonio and three campuses along the Rio Grande River, impacting several hundred miles of the US-Mexico Border. We collaborate closely with the renowned military medical centers in San Antonio, many public and private health organizations throughout South Texas and the South Texas Veterans Health Care System, led by Mr. Jose Coronado. We truly have a unique mission, impact and opportunities among the Nation's health science universities.

On behalf of Dr. Cigarroa and Mr. Coronado, we applaud this Congress' enactment of Public Law 107-287 which recognizes the responsibility and tremendous impact the assets of the Department of Veterans Affairs can have on the health and preparedness of our Nation. Thomas Jefferson said 200 years ago that "The health of the people is really the foundation upon which their happiness and the power of the State depends". With the new threats and vulnerabilities we face, that statement is more pertinent today than it ever has been. The public's health preparedness is of vital national interest. We see responses at all levels – Federal, State, local, public and private - to improve our public health emergency response capabilities, as well as the biomedical research essential to giving us better products with which to protect our people. It is very appropriate that the Veterans' Health Administration, as the Nation's largest and most geographically dispersed health system, contributes its considerable resources and talents to the problems we all face.

Many Veterans' Administration Medical Centers have had long mutually-beneficial relationships with medical schools and have developed a reputation for excellence in education, training and research. Many also serve as a regional Federal Coordinating Center for the National Disaster Medical System. This is true of San Antonio's Audie L. Murphy Memorial Veterans' Hospital, where I experienced its clinical excellence in teaching as a medical student 25 years ago. Today I work closely with them in our community emergency response program, where they established the Federal Coordinating Center and Regional Medical Operators Center for all of South Texas and several hundred miles of the U.S.-Mexico Border on our University campus. The Audie

Murphy VA research portfolio has grown to one of the largest in the VHA and continues to grow due to the excellent faculty shared with the UT Medical School.

One of the main challenges our public health emergency response plans face is filling in the requirements in manpower gaps due to new casualty estimates brought on by vulnerabilities from weapons of mass destruction, threats heretofore addressed by our Nation's Military forces, but now potentially directly impacting communities at home – large and small. Where in the past, local and regional plans generally considered casualties in the hundreds, now they must address estimates exceeding several thousand or more. This is indeed a new era - and the VA can help with buildings, clinical surge capacity - some of which must be mobile.

It was my pleasure to serve 34 years in our Nation's military, having recently retired as the Commanding General of Walter Reed Army Medical Center. I experienced more than a handful of mass casualty situations with at least 100 injured including the terrorist attack on the Pentagon and the anthrax letters. At the direction of the Governor of Texas, as part of the Texas State Guard, I now command a new volunteer unit we are forming – the Texas Medical Rangers – which is in response to President Bush's call for a medical reserve corps. These are groups of trained, organized health care teams available to augment existing health care resources in communities impacted from a public health emergency or disaster. The Federal assets in the military, including its reserves, the VA and the commissioned corps of the U.S. Public Health Service represent the largest group of trained, mobile, reassignable health professionals in the country. Likewise, at the State level, we must recognize the tremendous potential of academic health centers - our Nation's medical schools - in contributing public health preparedness as a component of clinical surge capacity.

Your law establishing the Department of Veterans' Affairs Emergency Preparedness Act of 2002 envisions several medical emergency preparedness centers with missions to conduct certain research, provide education and training, and to be prepared in the event of a disaster or emergency to provide response capability. The unique environment in San Antonio and South Texas is ideally situated to fulfill all those missions with excellence and to have additional benefits in terms of adding to scientific knowledge in the areas of environmental and toxic exposures – an area of expertise developed at San Antonio's Brooks City Base. In addition, our research teams have access to one of the Nation's few BSL4 laboratories, which is at the Southwest Foundation for Biomedical Research.

San Antonio is the home of military medicine, a large active duty, retired military and veteran population. It is natural for a community with our Federal and State assets and the population we serve, to be involved in the continuum of clinical care and research to injuries and exposures from active duty to reserves to veterans and, indeed, to the general population in South Texas, many of whom are exposed to various levels of environmental exposures resulting in a certain amount of health disparities among our people.

The Veterans" Health Administration has seen considerable benefit and successes by organizing into Veterans' Integrated Service Networks (VISN). In implementing PL 107-287 with the critical mass of capabilities and leadership in San Antonio we are prepared to be part of a VISN-wide or multi-VISN regional emergency preparedness system ensuring that the Nation's investment in its Department of Veterans' Affairs contribute significantly to the education, training, community preparedness planning and biomedical research of regions across the country. We strongly urge funding for implementation of this well-conceived law.

In closing I would like to add that it is likely that many Federal agencies, including the newly-created Department of Homeland Security, will need to reassess how they need to re-orient their assets to accomplish their missions. This could include regional officers for DHS. I would suggest that the San Antonio geographic, demographic and other factors make it a key location for an International Center for Health and Environmental Security which would build on the synergy of having many Federal and State agencies in near proximity on the same campus.

Mr. Chairman, I appreciate the honor of appearing before your Committee today and sharing some of my personal thoughts as well as those of Dr. Cigarroa and Mr. Coronado. I would be happy to respond to any questions.

House Committee on Veteran's Affairs

Subcommittee on Health

March 27, 2003

Testimony of Thomas E. Terndrup, M.D.

University of Alabama School of Medicine

Chairman Simmons, members of the committee, good morning. I am Dr. Thomas Terndrup, Professor and Chair of the Department of Emergency Medicine at the University of Alabama School of Medicine and Director of the Center for Disaster Preparedness at the University of Alabama at Birmingham or UAB. Speaking for Dean William Deal of the UA School of Medicine, we appreciate the opportunity to address the committee today. I am here to speak in support of Public Law 107-287, the Department of Veterans Affairs Emergency Preparedness Act. Funding for the establishment of four VA centers of excellence should be established with utmost speed, to ensure that our soon to be future veterans and our citizens can be afforded the security improvements that those centers would bring to bear.

As a career emergency physician, I have treated thousands of victims of the seemingly routine, small-scale disaster incidents, such as those that occur on our nation's highways and communities daily. As an educator, I have had the opportunity to work with and train nurses, doctors, and other staff members in the necessary recognition and treatment of a wide array of these emergency disorders. However, none of those has been as challenging and important as the tasks at present, that is preparing our healthcare system and its personnel for responding to the consequences of weapons of mass destruction. In this effort, the vital relationships between VA medical centers and our academic health centers and universities must surely be tapped in order for our nation to be better prepared. Secretary Tommy Thompson has said "knowledge is the healthcare

systems greatest weapon" against terrorism. Academic health centers collaborating with VA medical centers are an important national asset, whose relationship can be immediately exploited to our nation's counter-terrorism efforts.

At the UAB, we formed the Center for Disaster Preparedness in 1999, in order to address issues associated with preparation for biological terrorist attacks and other disasters through broad-based, multidisciplinary research, training, and service programs. Local Birmingham VA personnel were instrumental in it's formation. The Center's goal is to provide a formal structure to facilitate collaborative efforts between experts from a wide range of disciplines in order to address the issues surrounding disaster preparedness.

Our experts in public health, drug delivery, medical operations, rare and emerging infections, and basic and clinical research work together in strengthening our nation's biological shield. These individuals work collaboratively in improving the awareness and preparedness of the health professions for possible Weapons of Mass Destruction or WMD incidents. We have built strong relationships with other universities in the United States, including Louisiana State and Vanderbilt Universities, who together with UAB comprise the National Health Professions Preparedness Consortium. UAB is also collaborating with other southeastern universities in responding to the NIH's call for Regional Centers of Excellence in Biodefense research. I am intimately familiar with the broad capabilities that such multidisciplinary centers can deliver.

Our collaborative disaster center training activities include the nation's only live-exercise based WMD course which achieves healthcare leadership integration in responding to WMD incidents. We achieve this through utilization and modification of Homeland Security's Noble Training Center in Anniston, Alabama. Our local Birmingham VA has been a key component of the design and implementation of these training missions. The VA's National Disaster Medical System and our local Disaster Medical Assistance Team have actively collaborated, and recently deployed to assist with the World Trade Center

attacks. The planning, coordination and training activities have included conferences on post-deployment health evaluation and optimization, essential in our post-"Iraqi freedom" world.

The University of Alabama School of Medicine is one of the nation's top educational, research and patient care institutions. It has ranked in the upper echelon of federally funded medical schools for over 20 years. Our faculty have risen to respond to virtually all health threatening events; HIV/AIDS, arthritis, heart disease, organ transplantation, cancer, anthrax, and others. Disaster preparedness is another example of our eagerness to serve the nation and the world.

Public Law 107-287 establishes Emergency Preparedness Centers at VA centers which have strong collaborations with qualifying medical and public health schools, as well as other appropriate research and educational activities. Though the mission of our VA is to provide care and assistance to veterans, it accomplishes this by providing a full range of patient care services, as well as education and research. A local example is a project at the Birmingham VA to evaluate ways of training physicians and nurses to detect patients that are victims of bioterrorist attacks. This project utilizes the advanced VA computer capabilities to provide training. The training programs were developed by the Agency for Healthcare Research on Quality and our UAB Center for Disaster Preparedness. This project will inform us not only about training VA personnel, but also about training community based healthcare providers nationwide.

Last year under the VA Quality Scholars training program at the Birmingham VA and UAB, Dr. Jessica Jones, a VA trainee in the program run by my colleagues, Drs. Catarina Kiefe and Norman Weissman, was trained by us in Bioterrorism Preparedness. This year she is employed in the Los Angeles County Department of Health Services, as the Assistant Director for Bioterrorism Preparedness.

Public law 107-287 creates a joint program between the Department of Veterans Affairs and the Department of Defense in which a series of model education and training programs on the medical response to the consequences of terrorist activities are developed and disseminated. The long history of collaboration between VA hospitals and medical schools, puts the VA in an excellent position to get this valuable job done.

In closing, let me point out that existing resources should not be reassigned for this proposal; rather additional resources should be added for this specific program. These resources will be instrumental in securing our homeland, and they will build upon the strengths of existing VA and academic health centers.

I thank you for this opportunity to present to you today.

Center for Disaster Preparedness
University of Alabama at Birmingham

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Description of Program

The University of Alabama at Birmingham (UAB) Center for Disaster Preparedness (CDP) was formed to address issues associated with preparation for biological terrorist attacks and other disasters through broad-based, multidisciplinary research, training and service programs. The Center's goal is to provide a formal structure to facilitate collaborative efforts between experts from a wide range of disciplines in order to address the issues surrounding disaster preparedness. To this end, the CDP has recruited a diverse membership and established itself as a university-wide UAB Center, with formal approval by the Board of Trustees occurring in June 2000. In 2001 UAB received over $325 million in extramural grants and contracts and ranked 19th in research and development funding from the National Institutes of Health; the School of Medicine ranked 17th in NIH funding.

The CDP is heavily involved in national and international training activities. It has developed an innovative web-based training program to help clinicians recognize and respond to possible threats. Funded by the Agency for Healthcare Research and Quality Contract (an agency of the Department of Health and Human Services) and conducted in cooperation with the UAB Center for Outcomes and Effectiveness Research and Education (under the co-leadership of Drs. Catarina Kiefe and Norm Weissman), the site has been designed to provide resource information and continuing education about rare infections and potential bioterrorist agents (accessible at http://www.bioterrorism.uab.edu). This educational material is available to over 350,000 clinicians, including the following disciplines: emergency medicine physicians, nurses, radiologists, pathologists, infection control practitioners, internists, family physicians, pediatricians, and dermatologists. As of October 2002, the site has had more than 1 million "hits" and has issued 1,230 continuing medical education certificates issued for health workers in 89 countries. In addition, the Birmingham Veterans Affairs Medical Center has recently been funded to modify and enhance the existing CDP screensaver and website to tailor to the unique clinician populations and electronic educational applications of Veterans Affairs Medical Centers (VAMCs). To date, there have been no efforts to formally test and implement bioterrorism preparedness interventions in the VA.

We are also working closely with the Alabama Department of Public Health (ADPH) in extending these and other educational opportunities especially for hospital-based personnel. Members of the CDP are assisting the ADPH in responding to requests from the CDC and HRSA, in better preparing

Alabama for responding to bioterrorism and natural outbreaks of infectious disease. The CDP is also collaborating with the South Central Public Health Preparedness Center (co-director Dr. H. Michael Maetz at UAB's School of Public Health) to develop scientifically grounded, audience tested, pre-event messages for use in weapons of mass destruction terrorism situations. The approach will be based upon a multi-sector collaboration involving three schools of public health, six state and local public health agencies, community organizations, the Centers for Disease Control and Prevention (CDC) and the Association of Schools of Public Health (ASPH).

The CDP has planned and organized annual bioterrorism preparedness conferences. The conferences bring together researchers, emergency response personnel, and public health professionals throughout the region to participate in educational sessions regarding the management of medical emergencies, EMS education, disaster planning, weapons of mass destruction (WMD) issues, and other related topics. Selected conference information can be viewed at http://main.uab.edu/show.asp?durki=55270.

The CDP has partnered with the International Nursing Coalition for Mass Casualty Education at Vanderbilt University School of Nursing and the National Center for Biomedical Research and Training at Louisiana State University to form the National Health Professions Preparedness Consortium (NHPPC). With support from the US Public Health Service Noble Training Center, the NHPPC recently completed three pilot courses. As reported in the USA Today, The Noble Training Center (NTC) is the only hospital-sized facility for live, exercise-based training in medical responses to WMD (12/3/02 USA Today accessible at www.usatoday.com/news/nation/2002-12-02-terror-training-usat_x.htm). This course, created to facilitate the development of a long-term, focused, threat-responsive National capability, is offered as a four-day training program to prepare healthcare professionals (physicians, nurses, EMS personnel, and hospital administrators) to perform effective responses to incidents involving weapons of mass destruction. As the Noble Training Center is transitioned over to the Department of Homeland Security, we look forward to continuing to offer these valuable training experiences with an emphasis on hospital based personnel. In addition, the NHPPC will develop a national curriculum for the health professions for WMD. The curriculum will build knowledge from an awareness level to that of clinically based competency.

The CDP has also contributed to the development of Alabama's only Emergency Medicine Residency Training Program. This three-year program provides 18 residents per year with a combination of emergency and disaster preparedness training. A disaster medicine research fellowship was created in 1999 and now has its third trainee, leading the NHPPC efforts.

The Center's research focuses primarily on clinical and translational research. The Disease Agent Clinical Research Component has an anthrax vaccine research program, a joint effort between the CDP and the Alabama Vaccine Research Clinic at UAB. Funded by the CDC, this 5-year contract will support the study of an FDA-approved anthrax vaccine (Dr. Mark Mulligan, principal investigator). Members of the Public Health Surveillance Component are involved in a Public Health Preparedness and Readiness Assessment funded by the ADPH and the CDC as part of a 3-year grant to assess response capacity and training needs. In addition, ADPH and CDP faculty members are involved in infrastructure assessment and stabilization. Pharmaceutical Preparations Component members are evaluating the availability of pharmaceutical stockpiles, investigating access and delivery issues, and

creating a mobilization plan. In addition, members of the Medical Response Component are involved in several educational activities, including the AHRQ contract extension to expand the web site's educational modules.

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"The Servicemember's Voice in Government"
Established 1968

STATEMENT OF

THE NATIONAL ASSOCIATION FOR UNIFORMED SERVICES

BEFORE THE

BENEFITS SUBCOMMITTEE OF THE HOUSE VETERANS AFFAIRS COMMITTEE

ON

ENTREPRENEURSHIP, PROCUREMENT, AND EDUCATION OPPORTUNITIES FOR VETERANS

PRESENTED FOR THE RECORD BY

THE NATIONAL ASSOCIATION FOR UNIFORMED SERVICES

MARCH 27, 2003

NAUS was founded in 1968 to support legislation to uphold the security of the United States, sustain the morale of the Armed Forces, and provide fair and equitable consideration for all members of the seven uniformed services: Active, Reserve, National Guard, Veteran, Retired and their spouses, widows and widowers. The Society of Military Widows (SMW) became affiliated with NAUS in 1984. Our nation-wide membership is now 160,000, with over 500,000 additional family members and support voters. NAUS is the only military association to represent all grades, ranks, components and branches of the uniformed services: Army, Air Force, Navy, Marine Corps, Coast Guard, Public Health Service, National Oceanic and Atmospheric Administration, their families and survivors.

Disclosure
The National Association for Uniformed Services (NAUS) has not received grants (and/or subgrants) or contracts (and/or subcontracts) from the federal government for the past three fiscal years.

INTRODUCTION:

The National Association for Uniformed Services supports all of the legislation being discussed today; H.R. 1460. The Veterans Entrepreneurship Act of 2003; H.R. 1712, the Veterans Federal Procurement Opportunity Act of 2003; and H.R. 1716, the Veterans Earn and Learn Act. As the combat portion of the very successful Operation Iraqi Freedom draws to a close, we must plan ahead to take care of those who have bore the burden of our nations battles. The bills discussed today, when enacted into law, will be a great benefit for these worthy patriots.

REMARKS:

H.R. 1460. The Veterans Entrepreneurship Act of 2003

This legislation would permit the use of GI Bill provided education benefits for certain non-credit entrepreneurship courses. It would also permit veterans enrolled in a vocational rehabilitation program to have self-employment as a vocational goal. Small business is the backbone of the United States economy. This benefit encourages veterans to pursue entrepreneurial studies, which will great increase the success rate of those veterans who choose to enter the small business arena upon their separation from the military. The legislation involving the vocational rehabilitation program also encourages these same goals. NAUS fully supports any program such as this, which will benefit our veterans as they return from war, and offer a wider range of educational options for those that strive for small business success.

H.R. 1712, the Veterans Federal Procurement Opportunity Act of 2003

The "Veterans Federal Procurement Opportunity Act of 2003" would benefit veterans in several ways. First the law would establish a development program for small business concerns owned and controlled by qualified service-disabled veterans. The program would also reauthorize the excellent programs of the national veterans business development corporation and the advisory committee on veterans affairs. When combined with the other provisions of this legislation, this proposed law would greatly increase the opportunities for small businesses run by veterans. This includes the enhanced ability to contract with the Federal government. NAUS fully supports these provisions. The benefit to the veteran is increased opportunity for business success. The advantage to the government is the benefit of a superior product and/or service provided by our high quality veterans.

H.R. 1716, the Veterans Earn and Learn Act

The apprenticeship and on-job training programs of the Department of Veterans Affairs greatly benefits veterans, while assisting employers who seek to hire and retain skilled workers. These VA programs establish an important link between the training provided to service members while serving in the Armed Forces and the training available in civilian settings for purposes of occupational licensing and credentialing. Ultimately these programs develop a more highly educated and productive work force in the civilian community. The availability of these programs is also considered an important recruiting tool for the military services.

This legislation, if passed into law would improve educational assistance programs of the Department of Veterans Affairs for apprenticeship or other on-job training, by modifying the benefit entitlement charges for certain on-job training programs, to encourage veterans to pursue this type of training while actually providing incentive payments for early completion of apprenticeship training. The law would also increase benefits for individuals pursuing apprenticeship or on-job training and related postsecondary classroom education training to encourage veterans to consider critical fields. The law even benefits the DVA and the veteran by including a pilot program to provide on-job benefits to train Department of Veterans Affairs claims adjudicators.

NAUS fully supports this legislation, because it provides formal skill training and documentation of the training provided to the veteran, while increasing the success rate of skilled veterans who choose trade fields after their departure from the military. The program also works as a recruiting tool, when it is highlighted as part of a comprehensive benefit package to encourage young men to choose the military for the tangible benefit of obtaining a skill that will help with their future success.

Reaffirmation of Veteran Preference:

In keeping with the precedent of hiring preferences as provided Desert Storm and Vietnam Era Veterans, NAUS supports extending similar preferences to those active and reserve members serving in Operations Iraqi Freedom, Enduring Freedom, and Noble Eagle.

OTHER RECOMMENDATIONS:

Please consider the following related recommendations to benefit our returning service members, both active and reserve.

Increase the standard GI Bill benefit, and eliminate the enrollment fee—such as recommended in HR 1212. (Chairman Smith introduced March 11, 2003)

Defer the Repayment of Student Loans for Activated Reservists.
Mobilized Guardsmen and Reservists who have federal Stafford and Perkins education loans are currently required to begin repaying those loans while they are still on active duty.
NAUS recommends that the period of their involuntary active duty be excluded from the calculation of their loan repayment start date.

Prevent the loss of MGIB Benefits Because Of Recall.
Reservists who are students are at academic risk if they are called up. Currently if a student has to discontinue a course of study for recall, under MGIB, Chapter 1606, those incomplete months of study are charged against their 36 months MGIB benefits entitlement period because they failed to receive credit for the course. A provision was passed to protect members serving during the Gulf War only.
NAUS recommends not reducing the benefits entitlement for the period that a student is called up for a contingency operation during mid academic session.

Increase the Length of MGIB Benefits for Reservists.
A Guardsman or Reservist can qualify for a Montgomery G.I. Bill Program from either active duty or commitment to six additional years of reserve drilling time. Demands of family, and both a civilian and reserve career often preclude the individual from a timely pursuit of education. Often, the clock on G.I. Bill benefits run out before they can be used.
Furthermore, in this economy, a person may need retraining midway in their civilian career. NAUS recommends an amendment to Title 38 to permit extended use of benefits. If the benefit cannot remain available until it is exhausted, then for Reservists a time restrictive clock should only start at the termination of their Reserve career.

Continue MGIB-SR for Reservists who are Involuntarily Transferred from Pay to Non-pay.
If a member is moved to non-pay through high year tenure or promotion, the Reserve Montgomery G.I. Bill (MGIB-SR) ends. Education benefits should be permitted to be continued if the member continues to drill in non-pay, and has qualifying years

Improve overall MGIB Benefits for Selected Reserve (SR).
The MGIB-SR benefit level should equal approximately 50 percent of the recommended MGIB benefit level, to maintain equivalence between MGIB and MGIB-SR. MGIB-SR is currently 47.6 percent of the MGIB, having declined from 48.6 percent of MGIB on October 1, 1991. The MGIB-SR benefit level should be high enough so that the program is seen as a reward for serving the country. Increase MGIB-SR benefits to maintain the viability of the MGIB-SR program in the cluster of reasons to join the Armed Forces Reserve.

Affirm Department of Veterans' Affairs as Financial Administrator of MGIB-SR
Since MGIB-SR is a Title 10 program, VA believes it needs DoD's permission and perhaps legislation to formulate communication messages. VA should develop a comprehensive communication strategy that includes better coordination with DoD as an essential feature. VA should collaborate with DoD to review the content and mode of delivery of all MGIB-SR messages. Build flexible and responsive education programs and delivery systems tailored to the needs of members of the Selected Reserves/National Guard.

SUMMARY

The National Association for Uniformed Services (NAUS) appreciates the opportunity to submit this statement for the record. The nation owes its gratitude to the armed forces of our nation. As, our service members return from conflict it has been our tradition to take care of these heroes in thanks for their service to our great county. Enactment of the legislation discussed today will give these veterans the opportunity to carry the tradition of success they have demonstrated in the military forward into the civilian world as successful contributors to our nation's economy. If there are any questions for the record or otherwise please contact Ben Butler, the NAUS Deputy Director of Legislation at 703-750-1342 x3005.

STATEMENT OF

PAUL A. HAYDEN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

SUBMITTED TO THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

THE DEPARTMENT OF VETERANS AFFAIRS'
EMERGENCY PREPAREDNESS ACT OF 2002 AND
FORCE HEALTH PROTECTION FOR ACTIVE DUTY MILITARY FORCES

WASHINGTON, DC MARCH 27, 2003

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.6 million members of the Veterans of Foreign Wars of the United States (VFW) and our Ladies Auxiliary, I would like to thank you for the opportunity to submit our views regarding the implementation of P.L. 107-287, *Department of Veterans Affairs Emergency Preparedness Act of 2002*, and efforts to coordinate force protection in the active duty military forces of the United States for those who may be exposed to chemical, biological, or radiological weapons of mass destruction in theaters of conflict.

Preventing a biological, chemical, or nuclear attack is of paramount importance to the security of the United States and to our troops stationed in the field. At the same time, if an attack were to occur, we must be prepared to handle it successfully.

Full implementation of P.L. 107-287 would move the Department of Veterans Affairs (VA) health care system, our nation's largest, one step closer towards total preparedness by establishing four medical emergency preparedness centers that would carry out research and rapid response laboratory assistance into the detection, diagnosis, vaccination, protection, and treatment of chemical, biological, and radiological threats to the public health and safety. In addition, the Act requires the VA to develop and disseminate education and training programs on the medical responses to the consequences of terrorist activities, furnish health care during major disasters and medical emergencies, and expand the number of VA assistant secretaries to manage this new workload. The VFW was glad to lend its support for this legislation last Congress.

Unfortunately, and to the detriment of the nation, it is our understanding that this law has not been fully implemented. While the Act authorizes $20 million for each of the fiscal years 2003 through 2007 to establish the four centers, these funds were not made available by the appropriators. Further, the appropriators acknowledged the need for VA to participate in major disasters and medical emergencies while incongruously withholding funding to expand the number of assistant secretaries to manage preparedness activities. To ask VA to implement these sections of the Act with existing funds would be inappropriate and unconscionable given the current inability of VA to meet demand for veterans' health care. Congress should be mindful that situations such as this place VA in a Catch-22 position.

As for implementing the educational aspects of the Act, we understand that VA is disseminating information to its employees obtained from the Department of Defense (DOD) on the diagnosis and treatment of chemical, biological, and radiological exposures. However, until these centers of excellence are up and running it is unlikely that VA will possess the in-house expertise needed to develop and train public health care professionals to the degree required by the Act.

Finally, with respect to the codification of VA's authority to furnish health care in major disasters and medical emergencies, I would refer the subcommittee to our testimony of October 11, 2001, before the full House Committee on Veterans' Affairs. While VA has certainly improved its inter-agency coordination since then, we feel that the actions taken by VA in the hours and days after the September 11, 2001, terrorists attacks exemplify what we would expect from VA today and in the future.

At this point, I would like to turn our attention to the issue of Force Health Protection (FHP). On January 24, 2002, we testified before this subcommittee that investigations conducted following the first Persian Gulf War pointed out that "'U.S. military forces were unprepared to fight a war in which chemical or biological weapons might be used' and 'both [DOD] and [VA] gave insufficient priority to matters of health protection, prevention, and monitoring of troops when they [were] on the battlefield and thereafter when they [became] veterans.' Further, and in our opinion, the most grievous finding was the failure of both agencies to 'collect information adequately about, keep good health records on, and produce reliable and valid data to monitor the health care and compensation status of Gulf War veterans' who were ill following their deployment to the Persian Gulf. As a result, basic research questions could not be answered; and

thousands of Persian Gulf War veterans continue to suffer from undiagnosed illnesses."

Since the end of the Gulf War, the post-Cold War environment has witnessed frequent troop deployments. Each of these deployments possesses their own unique set of health care challenges and concerns. For example, DOD physicians report that the military member may experience physical or psychological trauma resulting from a variety of factors, such as combat, environmental extremes, illness or infectious disease, injury, weapons of mass destruction, and potential environmental threats.

In an attempt to address the mistakes of the past, as well as current deployment health concerns, DOD developed FHP. According to DOD, FHP "uses preventive health techniques and emerging technologies in environmental surveillance and combat medicine to protect all service members before, during and after deployment. FHP is designed to improve the health of service members, prepare them for deployment, prevent casualties and promptly treat injuries or illnesses that do occur."

This proactive response has resulted in marked improvements in medical surveillance through the deployment of a interim theater medical information system that allows DOD to regularly and repeatedly collect, analyze, and disseminate uniform health information with respect to the battlefield. DOD has also made strides in the detection and protection against chemical and biological weapons by fielding an improved protective mask, a skin decontamination kit, an automatic injector for use against nerve agents, hand-held radiation detection devices, and the new chemical-biological suit--Joint Service Lightweight Integrated Suit Technology (JSLIST).

While DOD is to be commended for providing the best equipment and training in the world to our nation's soldiers, airmen, seamen, and marines, we remain concerned with the way in which they conduct baseline troop health assessments. Section 765 of P.L. 105-85 requires DOD to perform pre-deployment medical examinations and post-deployment medical examinations to include the drawing of blood. All of these exams are to be retained in a centralized location to improve future access.

Instead of fully implementing this law, DOD requires troops to *assess their own state of health* before and after deployments by filling out forms DD Form 2795, Pre-Deployment Health Assessment, and DD Form 2796, Post-Deployment Health Assessment. Further, this is

supplemented through serum collection conducted during HIV testing within 12 months of deployment.

Self-assessment is, at best, questionable. For example, how is an infantryman expected to know if he has an infectious disease? He cannot possibly know. That is exactly why P.L. 105-85 was enacted. Why take the chance of something going unreported or undetected when a physical examination and blood sample are more comprehensive and empirically sound? Until DOD fully implements P.L. 105-85, DOD and VA will not possess the valid data needed to answer basic research questions regarding the health status pre- and post-deployment of military members. Therefore, the potential to repeat the mistakes of the past are real.

The VFW believes that every veteran is entitled to a comprehensive career service member medical record of illnesses and injuries they suffer, the care and inoculations they receive, and their exposure to different hazards while stationed stateside and overseas. Further, the transfer of this health care record, coupled with the personnel file, from DOD to VA should be seamless because in order for VA to properly care for and compensate a veteran, it depends on accurate and timely information from the veteran's military health record.

In conclusion, we would again state our support for the full implementation of P.L.107-287, *Department of Veterans Affairs Emergency Preparedness Act of 2002* and Section 765 of P.L. 105-85.

Mr. Chairman, I thank you again for the opportunity to submit our views, and I will be happy to respond in writing to any questions you or members of the subcommittee may have.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

Hearing Date: March 27, 2003
Committee: House Committee on Veterans' Affairs Subcommittee on Health
Member: Rep. Simmons
Witness: Secretary Rumsfeld
Question # 1

Question: Prior to this hearing, were you aware of the mandate in Public Law 107-287 that prohibits VA from establishing these research centers? If so, what is your view of their potential contribution to helping determine effects of exposure to, and treatments to ameliorate, biological or chemical weapons?

Answer: The Department of Defense (DoD) is aware of the apparent conflict for the Department of Veterans Affairs (DVA) concerning Public Laws 107-287 and 108-7. The DoD recognizes the VA's outstanding potential for continued contributions in the areas of deployment health research and treatment. The DVA is also well positioned to contribute to a national response to a weapons of mass destruction threat to public health and safety.

Committee: House Committee on Veterans' Affairs Subcommittee on Health
Member: Rep. Simmons
Witness: Secretary Rumsfeld
Question # 2

Question: Most of the research funds provided by DoD on Persian Gulf War illness research have gone to VA principal investigators. Can you tell me why that is so?

Answer: Of all the government funds allocated for research on the illnesses of Gulf War veterans, roughly one-third of the funding has been awarded to researchers in each of the VA, DoD, and civilian academic communities, respectively.

The availability of DoD funds for such research is announced publicly through Broad Area Announcements (BAA). BAAs solicit research proposals from the general research community, including both government and non-government scientists. Proposals or protocols are accepted from any scientist who responds to the BAA. Proposals are submitted to an independent body for scientific merit review and those proposals deemed most meritorious are awarded funding on the basis of this competitive process and military relevance.

Committee: House Committee on Veterans' Affairs Subcommittee on Health
Member: Rep. Simmons
Witness: Secretary Rumsfeld
Question # 3

Question: Would you say it is fair to conclude that DoD places a heavy reliance on VA as a research arm for DoD's work to rectify the plight of some of the veterans of the first Gulf War?

Answer: Both the DVA and the DoD have robust scientific medical research programs. Although they have overlapping areas of scientific inquiry, their missions differ significantly. Therefore, their research programs have distinct differences. DoD medical and scientific research is focused on force health protection. Thus, the Department seeks to enhance the health and fitness of the force, prevent disease and injury, and restore the health of its personnel. The VA is more focused on the long-term health impacts of military service and therefore its research portfolio reflects that emphasis. To the extent that VA research develops findings that can be applied to the active force, DoD uses such findings to minimize potential long-term health effects of military service.

Committee: House Committee on Veterans' Affairs Subcommittee on Health
Member: Rep. Simmons
Witness: Secretary Rumsfeld
Question # 4

Question: We have apparently had murder committed by an American soldier against his fellow servicemen in the Iraq theater. Also, media reports indicated that one of the accused servicemen involved in the murder of his spouse at Ft. Bragg last year after serving in Afghanistan campaign recently committed suicide. Did these particular servicemen receive pre-deployment assessments such as you discussed and were they judged fit for service?

Answer: Service members are assessed prior to deployment in a number of ways, including informal evaluations by their chain-of-command. If there is a perceived problem, they may be referred to mental health counselors, chaplains or other support services. Prior to deployment, they proceed through the Soldier Readiness Processing (SRP) process, which also includes a medical assessment. The HHS HIPAA Privacy Rule as a general matter prohibits release of private health information to the public without the Service member's authorization.

Hearing Date: March 27, 2003
Committee: House Committee on Veterans' Affairs Subcommittee on Health
Member: Rep. Simmons
Witness: Secretary Rumsfeld
Question # 5

Question: What conclusions did you draw from the results of your special inquiry at Ft. Bragg? Would you provide the Subcommittee a written report of those conclusions and any actions you have subsequently taken to ensure mental health debriefings or counseling for returning combat veterans?

Answer: The conclusions and recommendations from the Ft. Bragg inquiry are contained in the enclosed report (portions have been blacked out for privacy reasons). The report was authored by the Army Office of the Surgeon General. The recommendations are under consideration.

FORT BRAGG
EPIDEMIOLOGICAL CONSULTATION REPORT

18 October 2002

Chartered by:
U.S. Army Surgeon General

FORT BRAGG EPIDEMIOLOGICAL CONSULTATION REPORT:
18 October 2002

IMPETUS for the EPIDEMIOLOGICAL CONSULTATION (EPICON):

In a 43-day period during June and July 2002, there was a clustering (grouping of cases in time) of four homicides of spouses of active duty soldiers stationed at Fort Bragg, NC—all cases allegedly perpetrated by the soldiers. Two of these cases also involved completed suicide after the involved soldier murdered the spouse. An additional homicide of an active duty soldier involving the wife as one of the alleged perpetrators also occurred during the same 43-day period.

These five cases generated significant national and international news coverage, and led to various media-reported hypotheses about potential etiological factors that might be involved. Prominent in the media reports were postulated links to the stress of deployment (since three out of the four soldiers had been deployed to Afghanistan), the potential effects of their combat experiences, as well as questions about the impact of potential neuro-psychiatric side effects of the malarial prophylaxis drug mefloquine.

Contemporaneous with the media's increasing awareness of these tragedies, the U.S. Army Office of The Surgeon General (OTSG) established a charter for an epidemiological consultation (EPICON) team composed of Army and Centers for Disease Control subject matter experts to consult with the local medical and line leadership at Fort Bragg. The primary goal of the EPICON was to assess and provide recommendations to OTSG to address potential systemic, cultural, and resource-limitation factors which might be related to the recent apparent clustering of homicides and suicides, as well as deployment-related behavioral health issues.

The EPICON's Charter included four broad goals: 1) Assess the pre- and post-deployment soldier and family education programs, practices, and support/clinical services relative to Service/DoD policies, procedures and requirements, 2) Organize relevant statistical data for comparative analysis, 3) Assess the specific data associated with the index cases looking for patterns, contextual factors, organizational dynamics, and medical issues which may have proximate causal and/or contributing significance, 4) Utilize the data from the index cases as a basis to assess the relevancy and adequacy of the Services' current systemic policies, procedures, and resource requirements.

After coordinating multiple agency collaboration, the EPICON members deployed to Fort Bragg on 26 August and worked for three weeks on site. Interview and focus groups involving soldiers, spouses, leadership, and other agency individuals relevant to the charter's Scope of Activity were conducted. This report summarizes the analysis and results of this U.S. Army OTSG-chartered EPICON effort.

DISCLAIMER:

Three of the five individuals involved in the index cases have been arrested and are pending criminal proceedings under the jurisdiction of local civilian legal authorities. This EPICON was never intended as a legal 'investigation' or to function in such a way as to augment information pertinent to potential civilian criminal prosecution/defense legal processes. As such, the data developed and reported on the three pending legal cases is limited and germane only to responding to the specifics of the EPICON Charter's "Scope of Activity" (Appendix A).

ORGANIZATION OF EPICON REPORT:

For purposes of ready reference by leadership, this report is organized much like a standard medical consultation report with the EPICON's FINDINGS and RECOMMENDATIONS provided initially, followed by a more in-depth discussion of each finding and recommendation with relevant supporting data and pertinent references.

CONTEXT FOR FINDINGS:

These family tragedies clustering at Fort Bragg are of great concern to the entire DoD and DA leadership at all levels. It is important to understand the findings and recommendations that follow to put these tragedies into perspective. Statistical data collected by the U.S. government indicates marital dysfunction and resulting divorce affects approximately 50% of all current marriages. Reported and unreported domestic violence in the context of marital dysfunction is not uncommon. Military marriages have their own unique challenges that are very common within the military services, but much less common in civilian society. These include: 1) frequent and often lengthy service member absences for training and mission deployments; 2) geographic separation of the military family from the couples' families of origin (hence military families do not enjoy the benefit of having extended family available to help support them in times of crisis or spousal separation); 3) demography of the military is relatively young and predominantly male compared to civilian society, hence the prevalence rate of behaviors related to family dysfunction appears higher; 4) most military families reside in local civilian communities surrounding military installations, hence the community dynamics that can either be protective or destructive to family integrity and function are influenced by those community norms and available/unavailable military and civilian community-based support services.

INDEX CASE DEFINITION:

A case definition was established. Index cases were defined as fatal intimate partner violence that involved an Active Duty (AD), Reserve, or National Guard (NG) soldier stationed at Fort Bragg, either as alleged perpetrator (4 cases) or victim (1 case) in June or July 2002. Note that only the four cases involving the soldiers as perpetrators were studied in detail.

FINDINGS:

1. **Statistically Significant Cluster.** The overall homicide rate among soldiers at Fort Bragg over the last 12 months is not significantly different than the national rate. However, the fact that all five of the index cases involved intimate partners, with two of the index cases involving suicide—all clustering in less than two months—is highly unusual, and analyses indicate that these represent statistically significant findings[1]. However, there was no discernible individual epidemiological link between any of the five index cases.

2. **Mefloquine Unlikely Cause of Clustering.** Mefloquine does not explain the clustering. Mefloquine (Lariam) was not prescribed at all for two of the four active duty index cases. The other two index cases did receive prescriptions for mefloquine, but there was no reported history of antecedent changes in personality or unusual behavioral symptoms documented. However, for one of the soldiers who was prescribed mefloquine, definitive determination could not be made about the presence of possible neuro-psychiatric side effects secondary to pending civilian legal actions. Concerns raised regarding mefloquine use by active duty personnel were: 1) reported inconsistency in the screening for psychiatric vulnerability, 2) medical documentation sufficiency, and 3) adequate risk communication during the prescription process.

3. **Marital Discord a Major Factor**. All of the active duty index cases were experiencing marital discord including recent or threatened separation. Two of the three index case-soldiers who had deployed to Afghanistan were returned from the operational theater early to address their marital problems, however they did not access available resources for support. Marital discord at Fort Bragg was a prevalent theme among all focus groups. The lack of TRICARE reimbursement for marital and domestic abuse treatment is an obstacle to assisting distressed military families.

4. **PERSTEMPO Contributor to Marital Discord**. There also exists evidence through focus groups that high operational mission demands requiring time away from home, i.e. PERSTEMPO, may have been a contributing factor, including inadequate time for family re-integration, unpredictable work schedules, and problems with leave management. The possible link between intimate partner violence and deployment experiences is also supported by published literature[2].

5. **Re-deployment Transition Program Execution Challenges.** The tragic events involving the two soldiers who returned early from deployment speaks to extant voids in soldiers' help seeking or access to needed support services when they most needed assistance. Programs do exist to support families, including ones that address pre/re-deployment 'transition' challenges inherent in the disruption of marital/family continuity (e.g., Family Readiness Groups—FRG, Army Community Services—ACS, Family Advocacy Program—FAP). However, the current variable resourcing, organizational stove-piping, and inconsistency in applying tailored

programs and processes to facilitate the marital reintegration requirements for soldiers and their spouses (particularly for unique AD cohorts—e.g., US Army Special Operations Command (USASOC), Reservists, etc.) in the context of operational missions is of significant current and near-term future concern.

6. **Flawed Model for Behavioral Health Services.** The current model of delivering services for domestic violence (DV), substance abuse (SA), and behavioral health (BH) care prevention and treatment efforts as expressed in Army policy, structure, and resourcing is perceived by experienced active duty medical professionals and consumers (leadership, soldiers and spouses) as flawed and counterproductive thereby discouraging early identification and therapeutic engagement. Involvement with FAP, Alcohol and Substance Abuse Program (ASAP), and/or BH services is perceived to be equated with the risk of potential premature career termination[3].

RECOMMENDATIONS:

1. **Recognize Marital Discord as a Pervasive Factor Impacting Mission.** Safe access to earlier care is needed to prevent progression to more serious dysfunction. Focus groups uniformly endorsed the success of unit chaplains as sources of marital support. The workplace-centric chaplaincy methods of care represent an ideal model for delivery of behavioral health services, as was demonstrated in the Pentagon after the attack on 9/11.[4 5] BH care should be made available for active duty families (particularly for junior enlisted spouses and for children) on-post where they already get the vast majority of their medical care. TRICARE network support also needs to be improved both by increasing the availability of appointments and by instituting reimbursement for marital, family, and abuse counseling.

2. **Commission Study on Impact of PERSTEMPO.** DA/DoD should commission a systematic study of the impact of deployment operational frequency and intensity on the health and welfare of soldiers and their families to definitively address the hypotheses partially supported by this preliminary work. This EPICON developed a significant amount of suggestive data that can assist in structuring such a study. The data suggest that PERSTEMPO and associated family disruptions in the context of variable deployment-redeployment transition programs/FRGs, and distrust of behavioral health care, ASAP, and family advocacy program services is significantly impacting families and may contribute in rare cases to tragedy. Of more systemic significance is that these rare family catastrophes may be a symptom of a wider family wellness problem. An analysis is needed regarding health outcomes, divorce rates, domestic violence, premature attrition, and other health risk behaviors associated with frequent peacekeeping and/or combat deployments, as well as analysis of health care delivery and barriers to treatment. Such analysis would provide more sufficient evidence regarding these important mission-related medical and personnel questions to help guide constructive policy changes.

3. **Re-Energize Deployment Transition Programs.** Current command sponsored deployment 'transitional' programs, including FRGs, should be re-evaluated as to

their content, effectiveness, consistency of resources, and how they are tailored to particular units. Transition programs may benefit from the presence of workplace-centric behavioral health professionals acting as consultants in a re-engineered care delivery model.

4. **Re-Engineer To Optimize Delivery of Integrated Behavioral Health Services.** Soldiers and families need proactive, accessible, and career-safe BH care (BH = mental health services + FAP + ASAP). The available evidence supports the need to reengineer our current BH prevention/clinical systems. The challenges in doing so are legion and will require the committed leadership of the Army to overcome predictable entrenched resistance. As presently configured, Army BH programs do not practice basic public health or preventive medicine principles for BH problems:

    - *screening* to treat proactively those most 'at risk' for BH dysfunction
    - *surveillance* for DV, SA and BH dysfunction indicators
    - systematic and integrated BH *data* collection and analysis
    - *accessible* and career "safe" pre-clinical and clinical interventions that are workplace-centric
    - *integrated* BH services delivery for DV, SA, BH dysfunction
    - Single *portal of entry* into BH care system with a common *core evaluation*
    - objective BH *program evaluation*

BH Care Re-Engineering Recommendations
BH Care = FAP + ASAP + MH

NEW FEATURE	RATIONALE
Systematic Screening	To identify & proactively treat those at risk
Single BH data system	Care continuity, integration, efficiency, evaluation
Surveillance-talking/surveys/data bases	Earlier care protects careers/marriages, >readiness
Pre-clinical, workplace-centric focus	Career-safe, promotes access, command-consultation
Integrated BH system--FAP, ASAP, MH	Forward-deployed BH professionals
Single BH professional liaison to units	Chaplain model— relationships/trust develop
Provides preventive& pre-clinical care	Including FRG consultation, etc.
Single portal of entry	Decrease confusion to commanders & soldiers
Single, core BH evaluation	Less redundancy, accurate info, ↓perceived danger
BH care for spouse/children on post	↓ barriers→ ↑care→ ↑ readiness/ ↑well being
TRICARE— improve BH network care	Improve access: earlier care while small problems
Cover marital, family, abuse probs	$ for V-codes→ no severe diagnosis→ earlier care
Address reimbursement levels, probs	Best providers take TRICARE last or not at all

DISCUSSION OF FINDINGS:

FINDING #1: **Statistically Significant Cluster.** Rare events such as homicide, which occurs at roughly a rate of 6 per 100,000 per year in the U.S. overall[6] (or 1/100,000/year for intimate partner homicide)[7] can cluster (aggregate in brief time periods) at times randomly. Although it appears that the overall homicide rate at Fort Bragg over the last 12 months is not significantly different from the national rate, there is no question that the fact that the index cases clustered over two months and all involved intimate partners is very rare. Analyses suggest that this was a statistically significant outbreak, despite limitations in applying statistical tests to such rare events retrospectively. Efforts were made to obtain indirect measures of distress on post by looking at health care utilization records and risk reduction data over time. These data were inconclusive and will require further surveillance. However, it is noteworthy that this EPICON was not able to obtain and develop comparative trends for FAP data at Fort Bragg and the rest of the Army for the surveillance period in question because of: 1) difficulty accessing central FAP data for the study period and interpreting local quarterly data, and 2) concerns about definitional changes in mild DV cases starting in 1999 which may affect background rates of one broad measure of community distress. Regarding the data from the index cases, there is no specific epidemiological link between the individual cases, although the demographics of the cases mirror those in civilian studies.[8] Threatened marital separation/dissolution and perceived imminent familial loss were likely very important psychological etiologic factors in the four soldier index cases.

FINDING #2: **Mefloquine Unlikely Cause of Clustering.** Mefloquine is unlikely to be the cause of this clustering. There was no evidence that mefloquine (Lariam) was prescribed for two of the four active duty index cases ([redacted]—see Appendix C). One of these soldiers had returned from Afghanistan several months prior ([redacted]). He was not prescribed mefloquine, based on electronic pharmacy (CHCS) data, medical records, discussion with unit members, and a negative postmortem toxicology test. Case [redacted] also was not prescribed mefloquine based on the CHCS data, the medical record, and the lack of deployment history in the past year. CHCS data indicated that the two other index cases had been prescribed mefloquine (case [redacted] and case [redacted]—the two soldiers who had deployed most recently to Afghanistan). One of these soldiers (case [redacted]) had mefloquine detected on a postmortem toxicology test. The other soldier is in custody and was not tested as a part of this EPICON effort because of pending civilian prosecution.

For the two cases for whom mefloquine was prescribed, there was no reported history of change in personality or psychosis, per USASOC Surgeon's office, Criminal Investigation Division (CID) records, and data made available from peer/leadership interviews, though direct interview data was not obtained for either one of these soldiers ([redacted]). CHCS data were also reviewed for four other AD suicides occurring among Fort Bragg soldiers since January 2002 and a soldier who had committed homicide in January 2002. None had a history of mefloquine prescription.

Based on focus groups and medical record review of one of the soldiers involved in one of the index cases, one of the concerns raised regarding mefloquine use by active duty personnel at Fort Bragg was the reported inconsistency in the medical documentation and risk communication during the prescription process. This factor, coupled with inconsistent screening of individuals who may be at increased risk for neuro-psychiatric side effects, does not meet prescribing standards according to CDC guidelines[9] or the latest drug company warnings/package inserts[10].

The systemic concerns about routine use of mefloquine among deployed soldiers is beyond the scope of this EPICON's charter, but was addressed by a recent Assistant Secretary of Defense for Health Affairs ASD (HA) response[11] dated 13 September 2002 to a Congressional query regarding the use of mefloquine. This response outlines the current plan to deal with real concerns regarding the safe use of mefloquine among military service members.

During the course of preparing this EPICON Report, the authors became aware that ASD (HA) was already engaged in responding to Congressional queries regarding the safe and appropriate use of mefloquine in deploying service members. Since this systemic-level question is well beyond the scope of the EPICON's Charter, any system-wide recommendations are most appropriately the purview of ASD (HA) and the military services' Surgeons General.

FINDINGS #3: Marital Discord a Major Factor, #4: PERSTEMPO Contributor to Marital Discord, # 5: Re-deployment Transition Program Execution Challenges. The deployment-driven disruption of marital/family dynamics has been and is of significant ongoing concern to DoD and the Army ever since it became clear several decades ago (with the inception of voluntary versus drafted service) that the four DoD services were going to continue to trend towards being predominantly a married force. With the end of the Cold War in the early 1990's, (and subsequent reorientation in mission(s) necessitating ever more frequent deployments by a post-Persian Gulf War downsized force), unit commanders at all levels working collaboratively with their unit chaplains, installation helping agencies, local BH assets, and others, have implemented pre-/post-deployment transition programs, FRGs, and other activities to attempt to mitigate against this well-recognized significant family stressor.

In deployment scenarios where significant numbers of soldiers are deploying simultaneously as units, the pre-/post-deployment preparations generally occur in a fairly thorough and structured way to the benefit of the deploying soldiers and their families. However, current resource constraints mandate that these efforts operate from a general assumption that 'one size fits all', and the resources that are available for these efforts come out of unit/command operational resources and borrowed manpower from other agencies.

Another challenge is that these deployment 'transitional' programs are the responsibility of individual unit commanders and as such there is no formal structured

organizational/institutional oversight that would allow for integration and additional resourcing at an installation level.

Of particular concern regarding the EPICON's three index cases who deployed/re-deployed prior to the subsequent homicide/suicide, was that two of these cases [redacted] involved soldiers who returned early from Afghanistan specifically in response to their requests for emergency leave to address perceived marital distress. The subsequent outcomes after their return speaks to extant voids in soldiers' help seeking or access to needed support services when they most needed assistance. The fact that Fort Bragg is at the forefront of the war in Afghanistan obviously raises valid questions that the recent intimate partner homicides/suicides could in part be related to the stresses of high PERSTEMPO after 9/11, combat/deployment experiences, and/or other factors related to military duty. Although there is no direct evidence proving such a link, data from the focus groups and the research literature support this hypothesis as having some potential validity.

Many of the soldiers who participated in focus groups reported that the pace of current operations is so high that there is not enough time for the soldier to adequately recover before the next deployment. Soldiers reported that even when they return from a deployment, they still don't have adequate down time to spend with the family as they receive additional taskings. Of particular note is how leave is managed at Fort Bragg. Nearly every group of soldiers interviewed from both the USASOC and XVIII ABN Corps, including the First Sergeants and Sergeants Major, reported that soldiers are not infrequently expected to take leave on the weekends and/or during holidays, in part because there is insufficient manpower to support the workload, as well as to avoid the appearance of losing leave that has accumulated above the maximum allowed at the end of the fiscal year.

Regarding published studies, one of the best available studies analyzed data from a large random sample of over 26,000 married active duty Army service members from 1990 to 1994 (95% male). This survey included detailed questions about intimate partner violence during the previous year and was conducted anonymously to encourage honest answers.[12] Self-reported severe aggression (defined as beating up, choking, or using/threatening the spouse with a knife or gun) in the previous year was reported by approximately 4% of the soldiers. There was a small but significant association with deployment and a "dose response" observed with longer deployment being associated with a higher risk of severe spouse aggression. The probability of severe aggression increased 16% to 35% above the baseline rate for deployments ranging from less than 3 months to greater than 6 months. Another study using the same Army database compared with a nationally representative civilian sample who had been given a similar survey found that after adjusting for age, race, and gender - the incidence of severe violence was 2.5 times higher among active duty service members than among civilians[13].

A study conducted among U.S. Army combat arms soldiers deployed on peacekeeping missions to Kosovo showed that the number of adverse experiences in

the operational setting in Kosovo (such as being shot at, seeing dead bodies, handling land mines, etc.) had a direct relationship to interpersonal problems reported on returning home.[14] Getting in physical fights, having serious conflict with family members, threatening or being verbally abusive, or having thoughts of hurting someone were reported significantly more frequently for those exposed to a greater number of adverse peacekeeping experiences. Among soldiers who had had more than 10 adverse operational experiences, 10% reported getting in physical fights, 20% reported threatening someone with physical violence, and 18% reported having serious conflict with family members or friends. Remarkably, this was not an anonymous survey, although it was conducted as part of a research protocol in which the questionnaires were kept separate from the medical record and therefore confidential.

Taken together, the published studies along with EPICON focus groups suggest a link between intimate partner violence and deployment experiences among Army soldiers, and lend biological/epidemiological plausibility to the hypothesis that high PERSTEMPO or other factors related to the current war environment *may be* indirectly related to the recent homicides at Fort Bragg. Focus group interviews conducted as part of this EPICON suggests that the PERSTEMPO, unpredictability of work schedules, lack of sufficient leave/down time, and problems with re-integrating after deployments are having significant adverse effects on the health of some military families. The four recent homicides of Army spouses at Fort Bragg provide an opportunity to examine the larger issues involving the health and support of military families. It may not be just a random coincidence that these tragedies are occurring at a time when PERSTEMPO has increased significantly at Fort Bragg since 9/11.

FINDING #6: Flawed Model for Behavioral Health Services. Although there was known marital distress in all cases, there was no record of any of the index case soldiers accessing BH services prior to these tragedies. EPICON-conducted focus groups of beneficiaries (e.g. soldiers and spouses), 'gatekeepers' (e.g. chaplains and on-post school counselors), commanders, and senior leaders, all consistently conveyed the conviction that engaging FAP, ASAP, or BH services, even if self-referred, is detrimental and often terminal, either directly or indirectly, to a soldier's career. In many cases, 'going downtown' was viewed as the only safe way of accessing professional BH care. Note that the TRICARE benefit does NOT include coverage for marital or family problems (V code diagnoses under DSM-IV) in the absence of diagnosed Axis I illness.[15]

Common to most Army installations, professional BH services are limited at Womack Army Medical Center (WAMC), Fort Bragg for non-active duty beneficiaries. As such, the TRICARE network is the exclusive funded source of BH care for spouses and soldiers' children. There is a documented appearance of a robust civilian BH service TRICARE network. However, soldiers, spouses, DoD school counselors, and WAMC BH providers all claim a paucity of TRICARE network capacity resulting in the inability to obtain timely appointments (particularly for children) or with long waiting times (2-6 months), adding to the feeling of lack of support and isolation that many family members feel.

For soldiers, routine self-referral to installation-based BH services, even in the absence of domestic violence, was typically perceived to be career endangering. These findings are consistent with a 1998 DoD Survey which found that only ~20% of active duty members perceived that it was truly career-safe to engage mental health services[16]. A recent DoD-wide data review[17] just published in one the nation's leading psychiatric journals confirms that 27% of DoD service members seen as an outpatient for any type of behavioral health diagnosis were no longer on active duty 6 months later compared to 9% of those who accessed care for all other medical conditions. These data reflect the perception that engaging BH services (mental health care, FAP, ASAP) have a high probability of resulting in career termination.

Based on the focus groups involving soldiers, spouses and leadership, there is also widespread lack of trust in the FAP, despite the fact that soldiers and spouses readily indicated that at times they do need marital help. Soldiers believe that their careers are over if they use or are referred to FAP. Even spouses admitted that family violence often goes unreported because of the impact that they perceive such reporting can have on the soldier's career and on the long-term health and economic stability of the family. Soldiers and spouses perceive that FAP views Army families as being either healthy or dysfunctional, with no middle ground where a family incident can go unreported/undocumented while the family gets needed help.

Although most expressed reluctance to access BH services because of their career concerns, soldiers and their families experience unique stressors because of these same careers. Focus group members highlighted that the Army stresses families and soldiers by moving (PCS) them, separating (deploying) them, and by exposing soldiers to physical and psychological dangers while their families bear the attendant uncertainties. The medical literature confirms that these latter service-linked trauma /war exposures affect a large portion of the population in clinically significant ways[18 19].

The EPICON's Focus group interviews highlighted the frustration of being aware of significant needs created by these military-unique stressors, with both BH providers and beneficiaries working and living within a system in which existing BH services are perceived as unsafe to access and/or just not available. Gatekeepers, particularly Chaplains and on-post school counselors, were convinced that there were significant unmet needs that either were not addressed by the Army's services or were subject to the default perception that 'if it's bad enough, they'll find a way to "get help downtown".

DISCUSSION OF RECOMMENDATIONS:

DA /DoD should commission a more formal study to address the hypotheses partially supported by this preliminary work. A systematic study to address the hypotheses raised by this consultation could be conducted as an anonymous survey of soldiers in various operational units on Fort Bragg and other installations, preferably before, during, and post-deployment, but could also start with a cross-sectional survey post-deployment. Factors that could be assessed include the relationship of deployment duration, PERSTEMPO, and combat experiences to depression, anxiety, post-traumatic stress syndromes (i.e. PTSD), alcohol, family violence, physical symptoms, and other health risk behaviors. Positive moderators, such as strong and compassionate leadership, predictable work hours, deployment transition/family readiness programs, and protected leave could also be studied. Expertise to conduct this type of research is available through the Walter Reed Army Institute of Research (WRAIR), the Centers for Disease Control, and other military and civilian organizations. WRAIR has already established collaboration with Centers for Disease Control and would be amenable to organizing such an effort, if there was sufficient interest and DA/local leadership support at Fort Bragg and other selected study installations. This crucial period of current/near-term future war is a very important and opportune time to conduct such a study for the current and future benefit of our Army's mission effectiveness and the welfare of our soldiers and their families.

Soldiers and families need earlier, more accessible, and career-safe behavioral health (BH) care. The available evidence supports the need to reengineer our current BH prevention/clinical systems in a way that emphasizes integrated delivery of care and preventive medicine/public health principles.

The recent events at Fort Bragg have raised the level of awareness of these issues on post and provide an opportunity to think "outside the box" with regard to how behavioral health care, alcohol/substance abuse treatment, family advocacy and social work services are delivered, marketed, resourced, and integrated. Re-engineering of behavioral health care delivery should also explore the complex dynamics surrounding the issue and thresholds of mandatory investigation and reporting of possible spousal violence. There are various models of care delivery that can be considered in a re-engineering process. For example, one potential model is to make nearly all outpatient appointments to the various behavioral health care services walk-in—no appointment necessary—episodes of care. Soldiers or commanders who called would simply be given times when the soldier can walk in and wait for an appointment. This is much simpler than attempting to get an appointment through TRICARE or having to determine if the soldier's condition is truly an emergency warranting an urgent evaluation (which can sometimes involve additional time making phone contact with a physician). Another model of behavioral health care delivery which could be considered is to deploy behavioral health resources closer to the units (workplace-centric), which would help to improve communication with commanders and NCOs, improve access to care, provide pre-clinical preventive services, and facilitate support of the primary "gatekeepers" such as chaplains, senior NCOs, company commanders, and commander's programs, such

as Family Readiness Groups. Chaplains can play a particularly important role in the interface between company commanders and senior NCOs and mental health services. In one study in a basic training environment, improving access to care through these methods paradoxically was associated with significantly decreased need for care and decreased mental health workload, probably as a result of empowering the primary gatekeepers (chaplains, etc.) and improving the direct contact between unit commanders and mental health providers.[20] [21] Pre-clinical (primary prevention) models have similarly improved access to career active duty members (enlisted and officers) in the BH response to the Pentagon attack.[22] [23]

Preventive and pre-clinical approaches that cross community and agency boundaries have also been prominent in the innovative approaches practiced by the Army Chaplaincy and promoted by the Office of the Deputy Chief of Staff for Personnel's (ODCSPER) recently re-engineered Army Suicide Prevention Plan. The model of using forward-deployed/workplace-centric personnel such as chaplains and others trained in suicide screening is an example of putting prevention into practice which is needed for the full range of BH difficulties (including domestic violence).

Both focus groups and medical practitioners reported that, for the most part, only active duty soldiers could be seen for BH issues within the direct care system at Fort Bragg. Therefore, short of hiring more BH practitioners, another essential component of making care more accessible would be addressing shortcomings of the TRICARE civilian network for delivering BH care services. Focus group findings validated what many career AD BH professionals have observed: whereas under CHAMPUS the best BH practitioners in the community sought to fill their practices with military beneficiaries, under TRICARE the better practitioners tend to take TRICARE cases as a last resort or not at all because of a minimalistic approach to clinical services reimbursement. Of particular importance is that the current TRICARE benefit does not cover counseling for marital or family dysfunction (including abuse) diagnoses (ie. DSM-IV, V codes); rather it requires documentation of a more serious and even more stigmatizing Axis I psychiatric disorder.

In addition to taking steps to make BH services more accessible, developing more effective primary prevention screening is also important. Recent and emerging studies suggest that there may be ways to target cohorts that are at higher risk for BH dysfunction. For example, large-scale studies have confirmed that cohorts that have experienced early adverse childhood exposures are at higher risk for a range of health risk behaviors.[24] [25] [26] [27] Not everyone in these risk cohorts go on to develop significant problems. However, these same studies underscore that BH dysfunctions tend to cluster in the same individuals and their families (e.g. substance abuse, higher incidence of sexually transmitted diseases, higher incidence of depression, higher incidence of suicidal behaviors, increased mortality, etc).

There is presently no integration of FAP, ASAP, and BH services and databases to make such a primary prevention and early intervention model a reality. FAP, ASAP, and BH delivery systems are segregated and stove-piped up to the DA level; each has

their own professional personnel, clinical records, and data systems which do not typically interact with one another, and which do not maintain good continuity of care over time and across PCS transfers to other installations. These and many other factors argue for an integrated system of BH access, service delivery, record keeping, data collection/analysis, and continuous program evaluation that moves towards seeing these difficulties as an interrelated whole. An integrated, current, and accessible data base could proactively contribute to promoting the social health and readiness of the individual soldier in much the same way that FORSCOM's and TRADOC's Risk Reduction Programs attempt to collate human resource data as a way of attempting to promote social functioning and readiness of military units and the entire military community.

As mentioned in the findings, the Army uniquely stresses soldiers and their families in ways that affect everyone, and yet it is perceived that only those with severe problems are seen by the BH care delivery systems, and that this often ends in career loss. Focus group members expressed the need for a safe middle ground where professional care may be accessed as safely and as readily as are Chaplains. Moving towards such a model makes sense from a clinical standpoint as well. As in other areas of medicine, early care for small problems usually prevents them from growing into larger, more pervasive, and severe problems. Problems that are successfully worked with before they cause collateral social damage have the added benefit of tending to promote the development of individual autonomy, social functioning, and psychological adaptability—key traits underpinning the high functioning expected of the Objective Force soldier.[28] When identified early, many BH difficulties lend themselves to a pre-clinical care where diagnosis, charting, or reporting need not even become issues. Chaplains refer to such proactive work as 'ministry of presence;' and in the still ongoing post 9/11 Pentagon work, it is referred to as 'therapy by walking around.' Forward-deployed BH professionals make it easy for the soldier to access pre-clinical support, for concerned commanders or colleagues to make informal referrals, and for the BH professional to gain a better sense of the contextual stresses facing an entire unit and thus the individuals in it. This more collaborative, less 'zero-defect' model of BH growth-facilitating care for the many (or even most over the course of a 20-year career) in lieu of the present 'career-terminal' clinical care for the overwhelmed few, recognizes that a soldier's social and family functioning is an integral part of his overall professional functioning and career success.

Army Transformation underscores the need for a re-engineered BH system: the Objective Force envisioned will require psychologically adaptable soldiers operating from emotionally sound personal and family platforms. A career-long learning model of ongoing soldier personal and family development in which accessible and collaborative BH care plays a role in promoting the growth of psychological resilience and adaptability, in both the soldier and his family, complements the Objective Force model concept of professional skills development - lifelong learning[29]. The appended reference[30] charts the contribution of a reengineered Army BH to Army Transformation.

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30

Re-engineered Behavioral Health contributes to Army Transformation

	LEGACY FORCE --present clinic centered system	**OBJECTIVE FORCE** --'Therapy By Walking Around'
Behavioral Health Model	Paternalistic Targets young problem soldiers	Soldier/Family Development… Lifelong Learning
Access to care	Gatekeeper clinical referral	Informal pre-clinical referral = TBWA
Focus	Patient-diagnosis-chart	Function enhancement-no chart
Who needs care	Problem soldiers	Most over a 20yr career/post-deploy/etc
Who recognizes need	Unit	Self/Family/Colleague/~Unit
Perception of who care is for	Serves the Army's needs	Serves the soldier's & family's needs
Career impact	Often 'the last stop'	Safe—protects career
'Who's responsible'	Command	Soldier/medical/command
Population penetration	Low-mostly 1st term enlistees	High—includes career soldiers
Command/medical visibility	Low-mostly 1st term enlistees	High—includes career soldiers
Readiness impact	Low-often too late	High—early help→ avoids larger problems
Soldier/family development	Low-career loss vs opportunity to learn	High—collaborative, **lifelong learning**
Positive collateral impact	Low	High—MVA's, DV**, ETOH, med utiliz
Post-Deployment impact	Low-untreated war-exposures b/c chronic	May prevent PGW type illness & PTSD

* TBWA = Therapy By Walking Around
**DV = Domestic Violence

Appendix A – EPICON's CHARTER

CHARTER 1 August 2002

EPIDEMIOLOGICAL CONSULTATION (EPICON) FOR THE CLUSTERING OF HOMICIDES-SUICIDES AT FORT BRAGG, NORTH CAROLINA JUNE-JULY 2002

1. ESTABLISHMENT, PURPOSE AND SCOPE.

a. ESTABLISHMENT. The Office of The Surgeon General (OTSG) established the epidemiologic consultation (EPICON). This Charter delineates the EPICON's purpose, membership, and specifies the scope of activities.

b. PURPOSE. The EPICON team will consult to the local medical and line leadership of units at Fort Bragg to assess and provide recommendations to address potential systemic, cultural, and resource-limitation factors which may be related to the recent clustering of homicides and suicides, as well as deployment-related behavioral health issues. Recognizing that deployment behavioral health concerns for service members and their families are not unique to Fort Bragg, the EPICON team will generalize its consultation to address service-wide policies, procedures, and resource requirements which may be constructively informed by their findings and recommendations.

c. SCOPE OF ACTIVITY.

(1) The EPICON team will:

(a) Assess pre- and post-deployment soldier and family education programs, practices, and support/clinical services relative to Service/DoD policies, procedures and requirements.

(b) Organize relevant statistical data for comparative analysis.

(c) Assess the specific data associated with the index cases looking for patterns, contextual factors, organizational dynamics, and medical issues which may have causal and/or contributing associational significance.

(d) Utilize Fort Bragg's index cases as a basis to assess the relevancy and adequacy of the Services' current policies, procedures, and resource requirements.

2. ORGANIZATION.

a. The EPICON team will consist of the following membership:

- Team Leader, Behavioral Health (BH) Consultant, US Army Medical Command (MEDCOM)
- SG's BH Consultants in Psychology, Social Work and Psychiatry
- Chief, Department of BH and Epidemiology, WRAIR
- Chief, Department of Operational Stress, WRAIR
- Representative from Center for Health Promotion and Preventive Medicine (CHPPM)
- Representative from U.S. Army Chief of Chaplains
- Representative from the Deputy Chief of Staff for Personnel (DCSPER)/program manager for the Army's Suicide Prevention Program
- Representative/SME from North Atlantic Regional Medical Command (NARMC)
- Representative/SME from Assistant Secretary of Defense for Health Affairs (ASDHA)
- Representative/SME from Headquarters, Forces Command (FORSCOM)
- Other representatives/SMEs as deemed appropriate by OTSG

b. The EPICON team will interface and coordinate with the local line and medical leadership at Fort Bragg, as well as other echelons of relevant line and policy leadership to accomplish the stated PURPOSE and SCOPE OF ACTIVITY above.

3. PROCEDURES.

a. The EPICON team will initiate their efforts to accomplish its PURPOSE effective the date of this CHARTER's approval, and anticipate a 4-day onsite visit to Fort Bragg, on or about 26 August 2002.

b. An inbrief from the EPICON team will be made available to relevant line/medical leadership the 1st day of the visit. An outbrief to the local line/medical leadership describing preliminary findings and hypotheses under consideration will be provided on 29 August 2002.

c. Access to locally and centrally available relevant data sources (clinical personnel, etc.) will be requested.

d. Interviews with relevant unit/medical leadership will be requested at Fort Bragg, and at higher echelons of line and policy leadership.

4. DELIVERABLES.

a. A preliminary written report of the EPICON's findings and recommendations (after review by USASOC to ensure that no classified information is inadvertently released) will be completed and submitted to OTSG NLT 30 September 2002. The final report's submission date is contingent on completion of any relevant data analysis.

b. Briefings (after review by USASOC to ensure no classified information is inadvertently released) of the EPICON's findings and recommendations to general/flag officers at all appropriate echelons, and ASD(HA) officials will occur as directed by OTSG.

c. No media communications will occur among the EPICON team members without the approval of OTSG.

< original signed >

KENNETH L. FARMER, JR., M.D.
Major General
Deputy Surgeon General

Appendix B - EPICON TEAM MEMBERSHIP:

[redacted], LTC, CH, USA
- Representative/Subject Matter Expert (SME) from U.S. Army Chief of Chaplains

[redacted], LTC, MS, USA
- Research Psychologist, Dept. of Psychiatry and Behavioral Sciences, Walter Reed Army Institute of Research

[redacted], DSW, MAJ, MS, USA
- Representative/SME from Center for Heath Promotion and Preventive Medicine (CHPPM)

[redacted], PhD, COL, MS, USA
- Clinical Psychology Consultant, Army Medical Department Center and School(AMEDDCandS)

[redacted], M.D., M.P.H.
- Medical Epidemiologist, Division of Violence Prevention, Centers for Disease Control(CDC)

[redacted], M.D., MAJ, MC, USAR
- Representative/SME from U.S. Army Special Operations Command

[redacted], MSW, COL, MC, USA
- Chief, Department of Social Work, Walter Reed Army Medical Center

[redacted], MD, COL, MC, USA
- Chief, Department of Psychiatry and Behavioral Sciences, Division of Neuropsychiatry, Walter Reed Army Institute of Research (WRAIR)

[redacted], MD, LTC, MC, USA
- Representative/SME from North Atlantic Regional Medical Command (NARMC)

[redacted], MD, COL, MC, USA
- Psychiatry Consultant, US Army Medical Command (MEDCOM)

[redacted], DSW, COL, MC, USA
- Social Work Consultant, US Army Medical Command (MEDCOM)

[redacted], LTC, MC, USA
- Representative/SME from Assistant Secretary of Defense for Health Affairs(ASDHA)

[redacted], DSW, COL, MS, USA
- Chief, Department of Social Work, Brooke Army Medical Center(BAMC)

[redacted] M.D.
- Epidemic Intelligence Service Officer, Division of Violence Prevention Centers for Disease Control (CDC)

[redacted], LTC, IN, USA
- Representative from the Deputy Chief of Staff for Personnel (DCSPER) and program manager for the Army's Suicide Prevention Program

[redacted], LTC, MS, USA
- Representative/SME from HQ, DA Family Advocacy Program Manager, Community and Family Support Center (CFSC)

[redacted], COL, CH, USA
- Representative/SME from Headquarters, Forces Command (FORSCOM)

APPENDIX C- EPIDEMIOLOGY, STATISTICAL ANALYSIS and INDEX CASES:

There were three primary epidemiological objectives:

1) Determine if recent events (homicides/suicides) represent a statistically significant outbreak or are consistent with expected rates. This objective stems from the recognition that rare events can sometimes cluster randomly.

2) Determine if recent events have occurred in the context of increases in other measures of distress installation-wide.

3) Identify any clinical, psychosocial, or medical factors that may be associated with the index cases, such as deployment, PERSTEMPO, and use of mefloquine.

EPIDEMIOLOGICAL INVESTIGATION: CASE DEFINITION / DENOMINATORS

Case Definition and Outbreak Period

Index Cases. A case definition was established. Index cases were defined as fatal intimate partner violence that involves an AD/ Reserve/or NG soldier stationed at Fort Bragg, either as alleged perpetrator (4 cases) or victim (1 case) in June or July 2002. Note that only the four cases involving the soldiers as perpetrators were studied in detail.

For comparison, rates of suicide, homicide, and intimate partner homicide-suicide pairs were calculated for Fort Bragg and for the Army population in general and compared with published civilian rates. Particular attention was given to the two-year period leading up to the current events, which included one year before and after September 2001. This was a natural comparison since the events of September 11, 2001 resulted in dramatic changes in the operational tempo resulting in changes to PERSTEMPO. Figure 1 shows the distribution of homicide cases at Fort Bragg over the two-year surveillance period.

Data on homicides and suicides occurring at Fort Bragg was obtained from the Army DSCPER Suicide Prevention Officer and from the CID and casualty offices at Fort Bragg.

Brief Description of Fort Bragg and Calculation of Denominators.

There are approximately 40,000 active duty service members stationed at Fort Bragg. Most soldiers are associated with various units of the XVIII Airborne Corps (representing 29,000-30,000 soldiers). The US Army Special Operations Command (USASOC) represents approximately 6,500 soldiers officially, and Womack Army Medical Center (WAMC) has approximately 700 soldiers. There are other smaller tenant activities, but the numbers quoted above capture the majority of soldiers

stationed on Fort Bragg. In an effort to get a feeling for the PERSTEMPO, the percent of AD soldiers deployed OCONUS was obtained for the XVIII Airborne Corps by month for the two-year reference period. This information was unavailable for other units, but it can be assumed that USASOC units had at least as high (probably much higher) PERSTEMPO during this period. The denominator of assigned personnel is consistently around 40,000 per month. However, the number of personnel deployed at any given period of time fluctuates from month to month. The red line shown on Figure 2 indicates the assigned number of soldiers from the above units minus the estimated number of soldiers deployed OCONUS. There were accurate figures available for the proportion of deployed soldiers from the XVIII Airborne Corps, and these figures were extrapolated to the USASOC units to calculate the estimated post denominator shown in the figures, although it is likely that USASOC had higher rates of deployed soldiers. Among XVIII Airborne Corps soldiers, the proportion deployed OCONUS averaged 3-6% each month from September 00 – November 01. From December 01 – August 02, the proportion deployed OCONUS increased to 8-19%. Thus, the average number of soldiers on post decreased proportionally in the most recent months (line shown on figure 2). These percentages only provide a rough estimate of PERSTEMPO, as they do not reflect the number of different deployments, duration of deployments, or the impact of training cycles that individual soldiers experience.

ANALYSIS OF EACH OBJECTIVE

OBJECTIVE 1. The first objective was to determine if recent homicides/suicides represent a statistically significant outbreak or are consistent with expected rates.

Suicides. Figure 2 shows the number of suicides by month at Fort Bragg over two years, compared with the estimated denominator. The suicide rate among active duty Army personnel stationed at Fort Bragg was approximately 13.5/100,000/year from September 2000-August 2001 and 16.4/100,000/year from September 2001-August 2002 (including the two murder-suicides). This difference does not reflect a statistically significant increase. Although this compares with a civilian suicide rate of 12.3/100,000/year, these figures are not comparable since the Fort Bragg population is predominantly a young male population and males have substantially higher rates of suicide compared with females. In one study of suicide rates among Army personnel from 1990-2000, standardization by age, race, and gender to the civilian population resulted in a 30% lower rate of suicide in the Army compared with the unadjusted official rates reported by the Army (Eaton, Hoge, et. al. unpublished data, WRAIR). Extrapolating these data to Fort Bragg would suggest that the demographically adjusted suicide rate at Fort Bragg is 9.5-11.5 for the two reference years, comparable to the civilian rate.

Homicides Allegedly Perpetrated by Fort Bragg Soldiers. Figure 1 shows the total number of homicides in which Fort Bragg soldiers were either the perpetrator or victim, for a two-year surveillance period. Only one of these involved the Fort Bragg soldier as the victim (August 2002). Between September 2000 and August 2001 there was one

homicide perpetrated by an active duty soldier stationed at Fort Bragg. [redacted] Between September 2001 and August 2002 there were five homicides by Fort Bragg soldiers, all perpetrated against their wives. [redacted] Based on these cases, the homicide offending rate among Fort Bragg soldiers from September 2001 to August 2002 was estimated to be 12.5/100,000/year, compared to 2.5/100,000/year the previous 12-months. Additional data provided by the CID office at Fort Bragg indicated that there were 7 soldiers who perpetrated homicide between January 1997 and July 2000, the 3½ years prior to the surveillance period established for this consultation (rate ~ 5/100,000/year). (Only one of these cases involved an intimate partner.) These rates compare with a homicide-offending rate of 11.7/100,000/year among males and 1.3/100,000/year among females nationally (1999 data)(1). However, direct comparisons with civilian rates are problematic because homicides in the U.S. tend to be concentrated particularly in large urban populations that may not be comparable with the employed military population on Fort Bragg. Data on homicide offender rates Army wide from CID are pending at the time of this report. The rate of deaths due to homicide among active duty military personnel ranges from 2 to 6 per 100,000 per year (1990-1999, DoD Directorate of Information Operations and Reports-DIOR). These are all unadjusted rates.

Statistical Analysis of Homicides. During the one-year period from September 2001 through August 2002, there were five total homicides perpetrated by Fort Bragg soldiers and one involving the soldier as a victim. If we use the male civilian rate of 11.7/100,000/year, despite the problems with this comparison, it does not appear that the rate of 5 cases of homicide perpetration per 40,000 soldiers at Fort Bragg from September 2001 to August 2002 (12.5/100,000/year) is significantly above the civilian rate. However, what is extremely unusual is that all of these cases involved spouses. Intimate partner homicides only account for 11% of all homicides in the U.S. 1) The rate of dying by intimate partner homicide is 0.89/100,000/year for males and 1.43/100,000/year for females (overall 1.15/100,000/year); 2) Based on these expected rates, there should be less than 1 case of intimate partner homicide involving a soldier as offender every two years at Fort Bragg, and in fact the observed rate over the 4½ years from January 1997 through August 2001 was much less than this. According to the Fort Bragg CID office, there was only 1 case of intimate partner homicide involving the soldier as alleged perpetrator (and two others involving the soldier as a victim) during this 4½-year period (rate ~ 0.6/100,000/year). Given a baseline rate of no more than 1 case every two years in a population the size of Fort Bragg, then 5 cases over the last 12 months would be significantly above the norm ($p<.001$, Poisson rare event vs. standard); 3) The other unusual feature was the fact that the cases did not distribute randomly throughout the year, but appeared to cluster during a two-month period. Out of the six total homicides perpetrated by soldiers during the 24-month surveillance

period, four of them clustered during June and July 2002 (probability of this cluster: p=0.026, Scan Statistic for clustering). 4) If all homicide cases back to January 1997 are included, then the probability of a cluster of 4 over two months is 0.054. Considering only the intimate partner homicides back to January 1997, then the clustering over two months has a probability of <0.001.

Intimate Partner Homicides Combined with Suicide. Homicide combined with suicide is exceedingly rare, estimated to occur at a rate of 0.2-0.3 per 100,000 per year in the civilian population (5). Between 1999 and 2001 there were 9 cases Army-wide involving AD soldiers who killed their wives or girlfriends and then killed themselves, giving a baseline rate of approximately 0.6/100,000/ year (data provided by Army DSCPER Suicide Prevention Officer, source of data was CID electronic reports). None of these cases clustered by post. The higher rate in the Army compared with the published rate in the general civilian population probably reflects the demographic differences of the Army (young adult males) as well as inaccuracies in calculating the rate of such a rare event. Based on the expected rate of 0.6/100,000/year (the more conservative approach), even 2 cases at Fort Bragg in one year has a statistically low probability (Poisson, p=.02), and the probability of 2 or more cases occurring in a two month period is p<.001.

OBJECTIVE 2. Determine if recent events have occurred in the context of increases in other measures of distress installation-wide.

In an effort to determine if the recent events were occurring in the context of any other indicators of mental health distress installation-wide, rates of outpatient and inpatient mental health care utilization were calculated by month over the two years using the electronic ambulatory and inpatient data records. The rate of psychiatric hospitalization among active duty Army soldiers varied between 0.3 and 0.9/ 1000 soldiers per month with no clear trend over the two years (Figure 3). Regarding ambulatory behavioral health care use for mental disorder diagnoses (ICD-9 290-319) to all behavioral health care clinics, for every 1000 soldiers stationed at Fort Bragg, approximately 6-10 individual soldiers received one or more visits to behavioral health care clinics each month, and this rate remained relatively level over the two year period (Figure 4). Both of these rates are comparable to mental health care rates for the rest of the military (6).

In summary, health care utilization data provide potentially useful sources of indirect measures of distress on post. However it is difficult to draw firm conclusions from these data, and it will be important to continue to assess trends in these indices over the next several months. One clearly observable trend was the change in post population size related to a higher proportion of soldiers deploying since December 2001 (Figure 2), a indication of the increase in PERSTEMPO.

OBJECTIVE 3. Identify any clinical, psychosocial, environmental, or medical factors that may be associated with these cases.

To address this objective, information about each of the index cases were obtained through a briefing by CID and local law enforcement authorities, as well as medical records, CHCS, redacted copies of the Serious Incident Review Boards (SIRB), and other information provided by the units. The psychological autopsies on the two cases that involved suicide (cases 1 and 2) were also reviewed. Of note was that all of the index cases came from different units from USASOC and XVIII Airborne Corps and did not know one another. All of the homicides occurred in off-post residences. Regarding the likelihood of "copy-cat" behavior resulting from the sensational publicity, this is extremely difficult to study. Although the national media attention did not occur until late July and early August, there was local media coverage in Fayetteville shortly after the first murder-suicide on 6/11/02.

Description of Each of the Index Cases.

Homicide-Suicides:

Case 1. Date of incident: [redacted] Type of incident: [redacted]

Case 2. Date of incident: [redacted]. Type of incident: [redacted]

Homicides:

Case 3. Date of incident: [redacted]. Type of incident: [redacted]

Case 4. Date of incident: [redacted]. Type of incident: [redacted]

Additional Index Case. There was one additional highly publicized case that is distinct from the above cases because the victim was the active duty soldier (an AGR MAJ working at USASOC) shot in his home on July 23, 2002. The wife and 15-year old daughter are currently in custody facing murder and conspiracy charges.

Comment on Index Cases. Overall the demographics of the index cases are consistent with the literature on severe intimate partner violence and murder-suicide (2,5). The perpetrator is usually male, young to middle age, in a long-term relationship with the victim. Most of these cases involved marital discord and threatened or recent separation, which is also consistent with the literature. Although there was no clear evidence of past or present psychiatric problems, alcohol/ substance abuse, or a history of family violence we relied primarily on the briefings by CID and civilian law enforcement, as well as psychological autopsies completed on two of the cases. The information may not be complete. Regarding deployment histories, three of the soldiers had deployed overseas (Afghanistan), including one who had returned 2 days before the event, one who had returned ~2 months prior, and one greater than six months prior. Two of the soldiers who deployed to Afghanistan returned early due to their

marital problems. The level of combat experience was not known to any of the sources interviewed by this team.

Mefloquine. Regarding mefloquine, Table 1 shows the sources of data accessed to determine if any of the index cases had been prescribed mefloquine. [redacted] For the two cases who had been prescribed mefloquine, there was no reported history of change in personality or psychosis, per USASOC surgeon's office and CID records. However, interviews were not conducted with family members of one of the index cases who is in civilian legal custody. CHCS records were also reviewed for 4 other suicides occurring among Fort Bragg soldiers since January 2002 and the soldier who had committed homicide in January 2002. None had a history of mefloquine prescription.

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Table 1. Data on Mefloquine for four index cases:

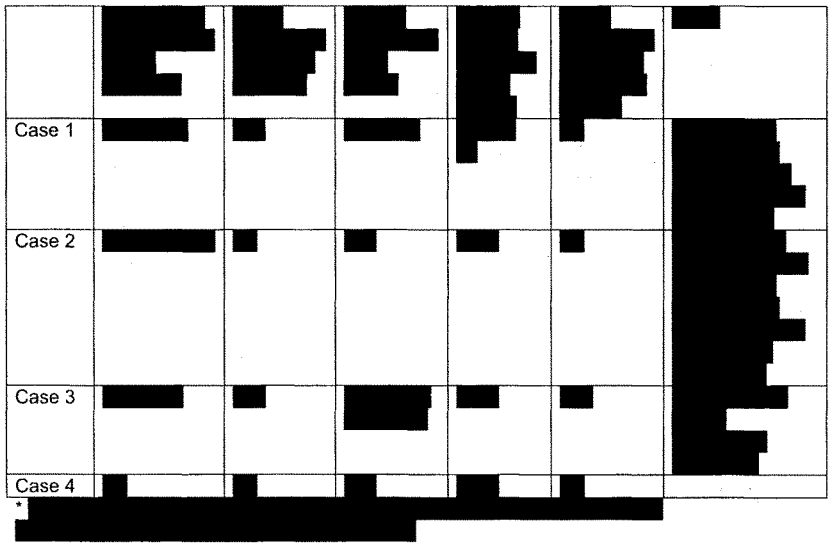


Figure 1.

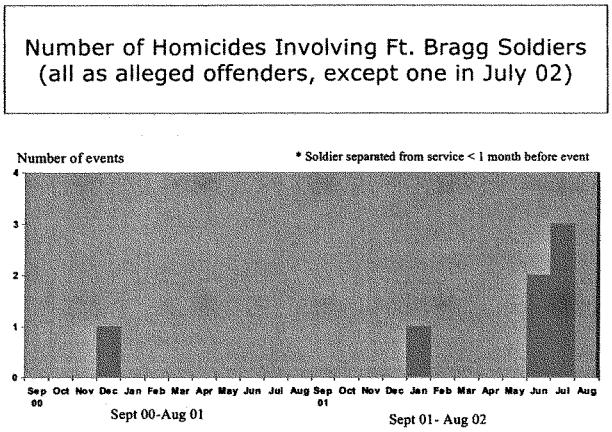


Figure 2.

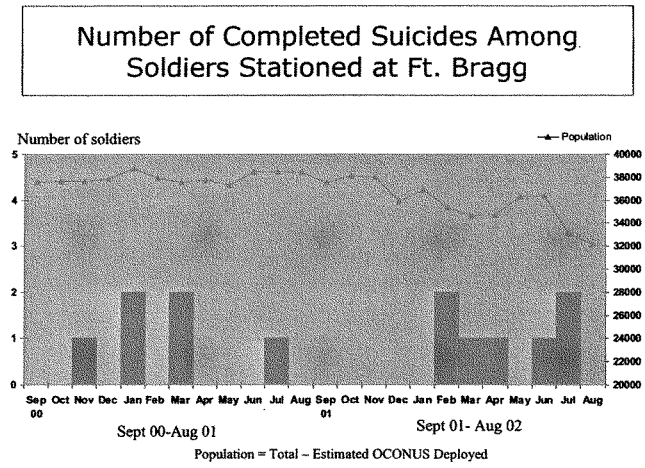


Figure 3.

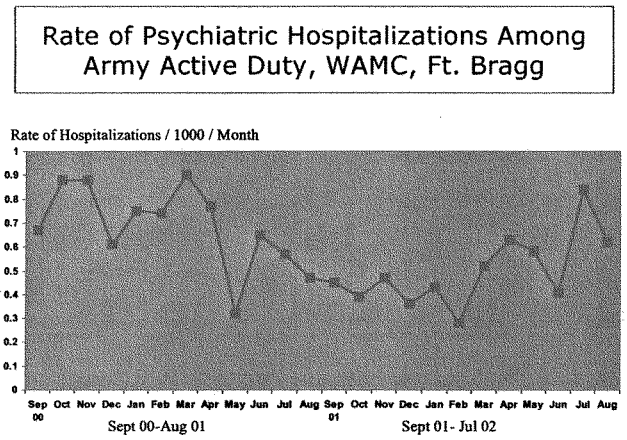
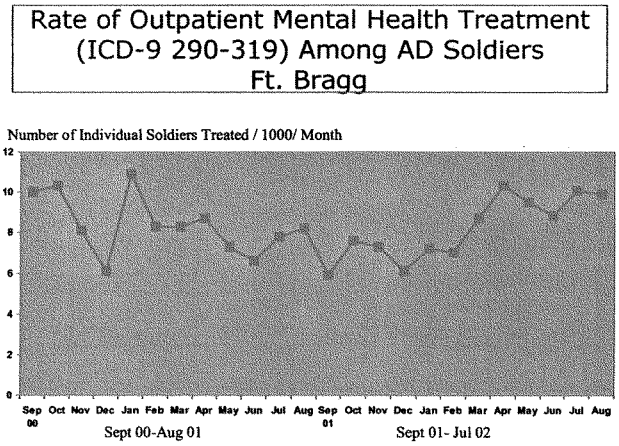


Figure 4.



APPENDIX D: SUMMARY OF EPICON FOCUS GROUP INTERVIEWS

INTRODUCTION

Small group interviews with representative soldier, leadership samples from XVIII ABN Corps, USASOC, Department of Defense Dependent School (DoDDS) counselors, and spouses were conducted to obtain user level perspectives on operational tempo (PERSTEMPO), behavioral health services, and organization/installation support. The purpose of the interviews was to address systemic, cultural, social, and psychological factors that exist at Fort Bragg that might have had some bearing on the index cases.

APPROACH

Focus Groups. Five interview teams, consisting of at least two EPICON team members, conducted all interviews. Thirteen focus group interviews were conducted with the following group composition from the USASOC and XVIII ABN Corps Commands:

USASOC

a. Junior enlisted
b. Noncommissioned officers
c. Medics
d. First Sergeants and Sergeants Major
e. Captain and Major commanders
f. Battalion/Brigade Commanders
g. Spouses

XVIII Airborne Corps

h. Junior enlisted
i. Noncommissioned officers
j. Medics
k. First Sergeants and Sergeants Major
l. Captain commanders
m. Battalion/Brigade Commanders
n. Spouses

In addition to the above group interviews, separate interviews were also conducted with chaplains and chaplain assistants and with DoDDS counselors.

Themes/Questions. Prior to all interviews, key themes and specific questions were determined that every EPICON interview team would attempt to address. In many instances, questions would not be specifically asked, if the issue was brought up spontaneously and discussed without the interviewer directly asking the question. In

some instances, the time allotted for the interview would expire before all questions could be asked and discussed.

Although the questions and themes varied depending on the specific group, there was considerable overlap. Below are the specific themes and questions addressed for each of the focus groups.

For the brigade and battalion Commanders and the Commanders in the rank of major and captain, the interview focused on the following themes: Perceptions of how PERSTEMPO is affecting soldiers and families. How are they adjusting? What is working well? What is not working well? How are deployments affecting the well being of soldiers? What are leadership perceptions of behavioral health care? Interview questions included: (1) How is the pace of operations affecting units, soldiers and families? Has it been different during your time at Fort Bragg? If so, how has it been different? (2) What have you been doing to meet these challenges of high PERSTEMPO? For example, what do you do to prepare families for deployments or long training exercises? Do you think these efforts are working? (3) What else do you think could be done to address this high pace of operations? (4) How have the events since 11 SEP affected the PERSTEMPO of your unit? (5) How have deployments impacted the soldiers and families? (6) If a soldier seeks help through one of the many Army services, such as FAP, marital counseling, anger management, is your perception of that soldier affected? (7) Tell me about your understanding of confidentiality if a soldier seeks behavioral health care. (8) If a member of your family needed behavioral health care, how would they obtain it? (9) What is important for us to know to bring to the attention of policy makers?

For Sergeants Major/First Sergeants, NCOs, medics, and junior enlisted soldiers, the interviews focused on the following themes: Perceptions of how PERSTEMPO is affecting soldiers and families. How are they adjusting? What is working well? What is not working well? How are deployments affecting the well being of soldiers? What are soldiers and units doing to adapt to deployments and the high PERSTEMPO? Interview questions included: (1) How is the pace of operations affecting the readiness levels of units, soldiers and families? (2) What is being done to prepare soldiers and families for separations due to deployments and long training exercises? Do you think these efforts are working? What else could or should be done? (3) What do you do to prepare your family for when you will be away due to deployments or training exercises? (4) How do you think the deployments are affecting family relationships? (5) How do you think the deployments are affecting the soldiers? (6) If a soldier seeks help through one of the many Army services, such as FAP, marital counseling, anger management, is your perception of that soldier affected? (7) Tell me about your understanding of confidentiality, if a soldier seeks behavioral health care. (8) If you or a member of your family is having personal problems, how would you access behavioral health care? (9) What is important for us to know to bring to the attention of policy makers?

For spouses, the interviews focused on the following themes: Perceptions of how PERSTEMPO is affecting families and children. How are families and children adjusting? What is working well? What isn't working well? What can be improved? Specific questions for the spouses included: (1) If you live on Fort Bragg and were a victim of domestic violence, who would you contact and/or where would you go for help? (2) If you live off-post and were a victim of domestic violence, whom would you contact and where would you go for help? (3) If you had a personal or family crisis, which you could not resolve, where would you go for help or assistance? (4) Are you aware of the family support services and programs available at Fort Bragg? (5) If you are aware of the family support services on-post, please provide two reasons why you would or would not use these services? (6) Are you aware of the family support services offered in the off-post community where you reside? (7) If you are aware of these services, please provide two reasons why you would or would not use these services. (8) What are three changes you would like to see in the family support services offered at Fort Bragg?

For the DoDDS Counselors, the interviews addressed the following themes: Perceptions of how PERSTEMPO is affecting family members especially children and adolescents. How are students adjusting? What is working well? What isn't working well? Specific questions for the counselors included: (1) What percentage of your students have parents who are either currently deployed or have deployed more than twice in the past year? (2) Describe any changes you have seen in student behavior, which you attribute to changes in the pace of military activities at Fort Bragg. How does it compare to other posts where you have been? (3) What are your students saying that suggests to you that they are or are not coping well with events in the world today to include the recent publicity concerning events at Fort Bragg? (4) If you have a student who needs professional assistance with personal problems, how does the health care system respond? (5) Do you think that your students believe that they have access to someone who will protect their right to privacy? (6) What is important for us to know to bring to the attention of policy makers?

Procedures. All interviews began with the members of the EPICON interview team introducing themselves and describing the purpose and objective of the interviews. Confidentiality and anonymity were guaranteed in order to encourage candid and honest discussion. Thus, no names of any of the group members were recorded. For all of the interviews, whenever appropriate, attempts were made to tabulate (i.e., quantify) the responses to questions. All interviews lasted approximately 90 min.

RESULTS

USASOC Junior Enlisted

The USASOC junior enlisted soldiers reported not having enough time to recover after deploying. These soldiers further reported not having the opportunity to take leave after returning from a deployment. They also reported that they were often told to "burn" leave by officially taking leave, but still coming in and working. The soldiers felt that the leadership didn't recognize how hard they were working. Regarding deployment preparation, these soldiers reported that the information about the deployment, such as when they were leaving, was constantly changing, which made making family plans very difficult. These soldiers stated that PERSTEMPO is adversely impacting the family. Also, these soldiers stated that their expenses while deployed exceed the amount they are reimbursed. These soldiers perceived that there is no such thing as confidentiality when a soldier uses the behavioral health services and that stigma is a real concern.

USASOC NCOs

This group consisted of 14 USASOC NCOs. There were 12 males and two females. The two females were married to other soldiers. The ranks for this group ranged from E-5 to E-8, with 10 being either an E-6 or E-7. The median number of years in the military was 12 years. The median number of years married was 7. These NCOs reported that PERSTEMPO is stressing the family and that there is not enough time to recover and refit after deploying. These NCOs also reported that when they return from a deployment that they are not given the time they were promised to spend with their families. These NCOs reported that many of the spouses were taking prescribed medications to deal with the stress. These NCOs reported that instead of getting to spend time with their families when they return, they sometimes have to perform taskings that seem mundane and further interfere with their process of re-integration. The leave system was also reported to not be working, as soldiers are not able to take the leave they are promised. These NCOs also reported that there is conflict with their spouses around the time of deployments and that their family readjustment process is never completed due to the short suspense timing of their next upcoming mission. They reported that this takes its toll on the family. They reported that the PERSTEMPO hurts their opportunities for education. These NCOs also reported that their deployment expenses are sometimes not sufficiently reimbursed, resulting in financial hardships. These NCOs reported that they wouldn't use the Army mental health services out of fear that it would hurt their career. Instead, they try to handle all problems with the unit.

USASOC Medics

This group of USASOC Medics consisted of 16 males, with the following ranks: two E-5s, 9 E-6s, and 5 E-7s. Fourteen of the medics were married. Eight of them had combat experience. These USASOC medics blamed the PERSTEMPO (i.e., the constant family separations, with little respite) for the many of the marital and family problems. All but one of the married medics in this group reported having marital problems. These NCOs reported that the wives were stressed and angry. Infidelity was reported to be a big problem that is hurting many marriages. This group of medics also stated that the policies on reintegration and post-deployment leave are often not followed due to the preparation for the next mission. These medics were concerned that the leaders keep raising the bar in order to stand out for promotion, and that this occurs at the expense of the soldier.

USASOC First Sergeants and Sergeants Major

The First Sergeants and Sergeants Major group consisted of 6 male soldiers. Their years in service ranged from 19 years to >25 years. Five of these NCOs were currently married. For two of these NCOs, it was their first marriage; for another it was his second; two others were on their third or fourth. The other NCO was divorced and had not remarried. The number of years they had been at Fort Bragg ranged from 12 to 25 years. This USASOC group of senior NCOs said that there is little or no time for families. Leave is either not being given or adequately used. The high PERSTEMPO creates more demand on home-stationed soldiers for taskings. They also stated that the system to help soldiers works against them. Specifically, soldiers won't use mental health services because it is a career ender. They also reported that there is a lack of confidentiality when using these services. This group of senior NCOs also reported that there is stress from a lack of planning that results from last minute changes. This group also stated that mission readiness is disrupted because of soldier concerns about the family.

USASOC Captains and Majors

The focus group with USASOC captains and majors included 8 males. Five were majors and three were captains. There reported number of years in the military ranged from 3 to 14 years. The number of years they have been at Fort Bragg ranged from 3 to 14 years. Seven of the eight were married, with the median number of children being 2. This group of officers stated that the PERSTEMPO was great and that they loved the real-world missions. They did state that the change in tempo does undermine trust and confidence in the leaders. Red cycle taskings also increase the stress level. They were also concerned that the rest of the Army has not shifted from the peacetime mentality to the near-wartime footing that they were on. These two modes of operating clash with organization of training, red-cycle (garrison) tasks, etc. The larger bureaucracy is not used to and has difficulty responding to fluid changes. This group stated that minor or temporary problems or problems that don't impugn on the character of the soldier are

ok, but that they don't have time for long-term problems. This group also stated that the FAP is biased against the soldier. This group was very upset with the mental health services at Fort Bragg, including both the USASOC and Womack Army Medical Center (WAMC) mental health support. Issues raised included lack of confidentiality, difficulty getting appointments, and the impact on the soldier's career.

USASOC Brigade and Battalion Commanders

There were 8 USASOC battalion commanders in this focus group. Their time in service ranged from 16 to 23 years. Eight were married and one was divorced. This group of battalion commanders believes that they are doing well based on both informal and formal evaluations. These commanders also stated that the Army does have a set of quality, comprehensive programs. But they also believe that those who need the services the most don't get it or wait until it's too late because of stigma, confidentiality issues, and fear about the impact on the soldier's career. This group was also felt they were not provided with the guidance, training, and resources to run Family Readiness Groups (FRG) effectively. These commanders also reported that when there are problems with domestic violence the only viable option to soldiers is to seek counseling services off post, because of the impact that this had on the soldier's career. Finally, they were concerned that behavioral health programs, FAP, and alcohol treatment services do not support commanders, and that there is a lack of outreach to the units.

XVIII ABN Corps Junior Enlisted.

The junior enlisted soldiers form the XVIII ABN Corps consisted of 23 junior enlisted soldiers in the rank of specialist to private. There were 18 male and 4 female soldiers in the group. Fourteen of the soldiers were married. These soldiers believed that deployments were adversely impacting marital relationships. This group reported that family emergencies and family issues are often considered not important. This group also reported that opportunities to take leave are not sufficient. Lack of information about upcoming deployments was straining relationships. These soldiers also reported that there is negative stigma to using mental health services and that confidentiality is poor.

XVIII ABN Corps NCOs

There were 20 NCOs from the XVIII ABN Corps in this group. Seventeen were males and three were females. Their ranks ranged from sergeant to sergeant first class. Their years in the military ranged from 4 to over 20. Some of these NCOs recently arrived at Fort Bragg, while others have been at Fort Bragg for over 10 years. Fourteen of these NCOs were married, 6 were single, and one was divorced. These NCOs reported that PERSTEMPO is reducing morale. They also stated that younger soldiers lack basic coping skills. There was the perception that the reduced time spent with the family due to the high PERSTEMPO is worsened by inefficient planning and focus. Training schedules are constantly changed and therefore provide soldiers with

no opportunity to plan their individual time and family time. These NCOs said that young spouses are less willing to support the unit the more time the unit takes the soldier away from the family. The perceptions of behavioral health care utilization varied. Some group members stated that they would respect soldiers who self-referred for behavioral health services. Others stated that their perception of that individual would likely change, with a sense that the soldier might need special support and consideration. Group members reported that overall access to medical services across the board is difficult, especially for family members. They reported that clinicians who are listed as TRICARE providers often do not accept the TRICARE system, or that waiting time for appointments can be on the order of several months.

XVIII ABN Corps Medics

This group consisted of 14 medics from the XVIII ABN Corps. Eleven were males and 3 were females. Their ranks ranged from private first class to master sergeant. Their years of Army service ranged from 1 to 20 years. Six of these medics were married, seven were single, and one was divorced. These soldiers reported that high PERSTEMPO was having a negative impact on families; soldiers have less and less time to deal with family/personal issues. Junior soldiers are not prepared for pace in infantry units, especially now with the rapid pace of deployments and multiple deployments for one individual in a short period of time. Units have less people now, but more taskings. The training schedule is constantly changing, at times with no work until 15:00 and then the unit required to work overtime. Family time is always listed on the training schedule, but often is not granted. There is a perception that soldiers are given little or no appreciation for their hard work. At times it is difficult for soldiers to access mental health services, especially for self-referrals. There is a perception of little to no confidentiality at unit for mental health services, in part because no services are available after working hours. In addition, attendance at programs such as stress or anger management is limited because classes generally are held only during working hours.

XVIII ABN Corps First Sergeants and Sergeants Major

There were 16 First Sergeants and Sergeants Major assigned to XVIII ABN Corps in this group. Fifteen were males and one was a female. Their number of years of service in the Army ranged from 15 to over 20 years. The number of years that have been assigned to Fort Bragg ranged from 2 to >15 years. Twelve were married and 4 were either single or divorced. This group of senior NCOs reported that the high PERSTEMPO is causing low morale and soldier burnout. This high PERSTEMPO makes it difficult to train junior leaders and for soldiers to take leave. Red cycle taskings also reduce the opportunity for soldiers to take leave. Families are negatively impacted from the high PERSTEMPO because the soldier is seldom home. This high PERSTEMPO reduces the spouses' willingness to participate in FRGs. This group also believes that behavioral health care needs are met too slowly or too late, and there is significant stigma. Some 1SGT/SGM's described situations in which they were told

soldiers would need to wait 2 – 3 months before an opening for a counseling or anger management appointment would be available. Other 1SGT/SGM's described a quick response in emergency situations, but reported frustration at the return of soldiers following evaluation for on-going unit watch, which further stressed resources in the unit.

XVIII ABN Corps Company Commanders

There were 17 Company Commanders assigned to the XVIII ABN Corps in this focus group. Fifteen were captains and two were first lieutenants. Thirteen were males and four were females. Their years of service ranged from 3 to 13 years. Twelve were married and 5 were single. This group of commanders reported that the high PERSTEMPO is having significant impact on families, and that soldiers are "getting hammered" by various red cycle tasks. They believe that there needs to be emphasis on FRGs, and that participation rates are very low. They also reported that there is no confidentiality when soldiers use the mental health services, and that the stigma of using them will hurt their career. These commanders reported that they themselves are reluctant to refer soldiers to installation support programs because of the adverse impact that it can have on their careers.

XVIII ABN Corps Brigade and Battalion Commanders

There were eleven battalion commanders in this group, with one major representing his battalion commander who could not attend. All were male. Their years of service ranged from 13 to 25 years. Their time at Fort Bragg ranged from 2 months to 25 years. All were married, with their time married ranging from 9 to 24 years. This group of commanders reported that there are unnecessary training exercises. Further, they believe that duties such as post guard duty and maintenance should be contracted out, since soldiers are already maximally stressed with collateral duties. These commanders said that they don't think any less of a soldier who seeks help for personal problems. However, one commander did add that real "warriors" don't seek help no matter how much commanders encourage their troops to do so. This group also believes that junior enlisted soldiers are more likely to come forward than are NCOs. Chaplains are viewed as a critical resource that needs to be better supported.

DoDDS Counselors, Fort Bragg

This focus group consisted of DoDDS Counselors who worked at the schools located on Fort Bragg. Of the twelve counselors in this group, 9 were females and 3 were males. The DoDDS counselors estimate that nearly a third of children have some type of behavioral, learning, or mental health problem. They also reported that access to mental health care was virtually non-existent for children, and was viewed as the number one priority. They reported that child psychiatrists are booked several months in advance, and other therapists that treat children also take two months to get appointments. Although TRICARE reports that services are available, when parents call the numbers provided by TRICARE they are either told the therapist or psychiatrist

is no longer available or is only taking a limited number of TRICARE clients. They also believe that parents are often afraid to ask for help for fear of the request negatively affecting the soldiers' career. The DoDDS counselors also noted that deployments disrupt the child's routine, which is compounded by the reported observation that due to PCS moves, and deployments (which sometimes results in children being sent to live with grandparents/other relatives) a large percentage of the student population changes each year.

USASOC Spouses

There were 7 spouses of USASOC soldiers and officers in this group. All were female. The ranks of their husbands included two officers (COL and MAJ), three senior NCOs (two SGMs and one SFC), and two junior soldiers (SGT and SPC). There were at least 6 different units represented in this group. The USASOC spouses felt the orientation/sponsorship program was inconsistent. All the spouses thought that there should be mandatory spouse orientation and indoctrination to unit/installation support services. The spouses reported that the installation family support programs are not working well. The USASOC spouses also felt there was no support connection between the senior spouses to the junior spouses. The spouses of the junior enlisted reported that many spouses encourage other spouses to do things that don't help the marriage when soldiers are deployed. All the spouses acknowledged their own reluctance to use FAP as an option for seeking assistance due to the stigma associated with FAP and due to the mandatory investigation and disposition process that may result in adverse consequences, not only for the soldier, but also for the economic stability of the family. Although there was appreciation of some of the FRG and AER support services, many spouses felt that they did not know how to adequately access services, and there were mixed perceptions on their usefulness. The spouses also expressed the need for an early intervention program that prevents the escalation of marital/family abuse that didn't result in formalized reporting. This group of spouses reported that it takes 6-8 weeks to get an appointment with a mental health provider through TRICARE.

XVIII ABN Corps Spouses

Two separate focus groups were conducted with spouses whose soldier was assigned to the XVIII ABN Corps. One of these groups consisted of five spouses, while the other consisted of 11 spouses. All of the spouses were females, with one spouse being prior military. There were at least six different units represented in this group. Nine officer spouses and seven enlisted spouses were in the group. Years in the Army ranged from 1 to 25 years. Years at Fort Bragg ranged from 2 months to 6 years. Years married ranged from 1 to 25 years. For the group of 11 spouses, ten had a least one child, with the median for both groups being 2 children. Three of the 16 spouses lived on post. According to these spouses both they and soldiers are "stressed out." PERSTEMPO is considered a major source of family problems. Several spouses reported taking medication for the first time in their lives in order to deal with the stress that exists at Fort Bragg. Much more work with service members and families is

needed regarding pre-deployment, deployment and post deployment dynamics. Spouses expressed a very low sense of support from military community. There are major concerns about awareness of and access to resources, on and off post, and complaints of poor customer service at on-post agencies. FRGs are not considered particularly useful/effective in their current form. Lack of confidentiality was also voiced as a concern. Chaplains, friends and family are primary points of contact regarding problems, although some spouses even voiced concern over using the uniformed chaplains.

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Committee: House Committee on Veterans' Affairs Subcommittee on Health
Member: Rep. Simmons
Witness: Secretary Rumsfeld
Question # 6

Question: Did the Ft. Bragg situation cause you to re-think your policy on force protection, especially in the area of mental health?

Answer: The Department of Defense takes the mental health of Service members very seriously. In 1999 the DoD published a directive, 6490.5, "Combat Stress Control."

We have a number of mental health assets which we deploy. There are combat stress control teams, divisions on mental health, stress response teams, psychologists on aircraft carriers, etc. All assets have received special training in combat stress control.

During the redeployment process, the Services require each returning individual to respond to a short health assessment questionnaire that inquires about health in general and mental health concerns. Affirmative answers prompt further exploration of the Service member's problems or concerns by a trained health care provider. The findings of that further assessment may require immediate intervention or specific referrals for in-depth medical or mental health evaluation as appropriate.

These medically-oriented activities are in addition to the continuous opportunity for unit leaders and peers to identify, and affect intervention for, physical and mental health problems among Service members before, during, and after deployments.

Committee: House Committee on Veterans' Affairs Subcommittee on Health
Member: Rep. Simmons
Witness: Secretary Rumsfeld
Question # 7

Question: What is your plan to treat an active duty member who is exposed to a chemical weapon in Iraq? What is the treatment protocol for exposure to a chemical weapon? When did the last such exposure occur, and what is the state-of-the-art in treatment of chemical or biological weapons exposures?

Answer: The Department of Defense has developed systems to detect the presence of chemical weapons in areas or situations that may pose a threat to DoD personnel. Commanders, Service members and medical personnel are well trained in the actions to take to prevent exposure and treat acutely affected Service members. This includes donning Mission Oriented Protective Posture (MOPP) gear and masks, decontamination procedures and the treatment of chemical causalities. These procedures are repeatedly exercised in training situations and level of threat awareness among our forces is very high.

In the event of exposure below a level that causes acute health effects there is no agreed upon treatment protocol or even agreement that anyone needs treatment. Actions that can be taken include recognition that such an event occurred and medical surveillance (potentially long-term) of those exposed. The use of biomarkers of exposure is an area of interest, but few validated markers, that can be employed immediately in a combat setting, exist for chemical weapons.

Service members will be treated if they are exposed to harmful amounts of chemical warfare agents, as evidenced by either the onset of characteristic signs and symptoms linked to a possible exposure or by the recognition of unprotected exposure to amounts of agent likely to cause injury. Service members who have been in the vicinity of the release of a chemical warfare agent while fully protected from the harmful effects by MOPP gear, most likely will not require any treatment. Protection can be achieved through avoidance of the area of release and dispersion, wearing of the individual protective clothing and mask, or through collective protection. Treatment will be necessary for casualties or probable casualties. For nerve agents, the first line treatments consist of the antidotes atropine and pralidoxime. Additional treatment will depend upon the degree of intoxication, the efficacy of the antidotes, and may include intensive medical management to support the respiratory system. For vesicants, treatment includes prompt decontamination of the affected sites (if possible) and supportive care of the injured tissues.

During the Gulf War of 1991, any exposures to chemical warfare agents that may have occurred were not recognized as such at the time because Service members did not develop symptoms indicative of such exposure or requiring treatment. The one possible exception to that situation was the case of a soldier who developed a skin blister after inspecting a captured bunker. A vesicant agent may have caused that blister. The most recent instances of exposures leading to symptoms and death did not involve U.S. military personnel. Chemical warfare agent exposure occurred among non-U.S. personnel during the Iran-Iraq war when many deaths and injuries were attributed to use of nerve agents and mustard gas. Human exposure also occurred in the

civilian Japanese population during the terrorist releases of sarin nerve agent on two occasions in Japan during the mid-1990s.

Treatment for chemical agent exposures is along the lines described above, with specific treatment choices based upon the nature of the agent. Treatment of biological exposures is likewise based upon the nature of the agent. For example, exposure to a known infectious bacterial agent like anthrax would be treated with antibiotics appropriate to the agent. There are no antibiotics proven to be effective for viral biological agents, so treatment would be supportive. That state of affairs explains why the employment of effective vaccines, when they exist, is key to blunting the threat from viral biological agents. Treatment of biological toxins also would be tailored to the nature of the agent, although such treatment would be primarily non-specific, supportive care. In the case of botulinum toxin, the only specific kind of therapy possible would be botulinum antitoxin, which is currently an investigational new drug.

Committee: House Committee on Veterans' Affairs Subcommittee on Health
Member: Rep. Simmons
Witness: Secretary Rumsfeld
Question # 8

Question: Please describe the process by which Service men and women are medically examined prior to deployment. What is the percentage of soldiers who are doing self-assessments versus those who received actual clinical examinations before being deployed? Do you still believe that self-reporting is a sufficient means to monitor the health of a soldier? Why?

Answer: The medical and physical standards for people in the military services are designed to recruit and retain people whose physical and mental status are sufficient for them to withstand the rigors of deployment. These principles underlie the practices that have come to be designated Force Health Protection (FHP). The three major goals of FHP are to sustain a fit and healthy force, to protect that force from disease and injury, and to restore the health of those who have become sick or injured.

The process begins during recruitment, when every prospective recruit undergoes a thorough medical history, physical examination, and selected laboratory tests. If an applicant for military service meets the accession physical and medical standards, the new recruit is reevaluated during initial entry training. That evaluation includes not only medical screening but also the response to challenges imposed by the military training itself. The physical and psychological rigors of this introduction to military service may provoke health problems. When such problems cannot be treated or cured, they prove to be the basis for disqualification from further military service. Attrition during the first year of service is relatively high because of some recruits' inability to meet the standards for retention. Service members retained after one year have proven to be even healthier than those initially recruited.

During subsequent military service, members are subject to varying types of performance assessments and medical evaluations. Examples are periodic physical examinations, examinations required as part of occupational medical surveillance, special examinations for certain kinds of duty (e.g., flight physicals, submariner's exam), and examinations conducted as part of an evaluation for illness or injury. In all such medical examinations an important consideration is whether or not the findings may preclude the individual from being deployed. If a finding renders an individual non-deployable, then that fact must be considered in deciding whether an individual may remain in the Service. In a similar way, non-medical assessments, such as periodic physical fitness tests and evaluations of duty performance, influence decisions about suitability for deployment and, therefore, retention in the Service.

The result of these initial and continuous evaluations for health and fitness is a population of Service members who are each individually and repetitively assessed as being deployable or not deployable. All Service members who receive deployment orders are again screened to ensure that no new change in their health status has occurred since their last detailed evaluation. This assessment is required no matter how recently or remotely the Service member may have undergone other medical assessments. In other words, it does not matter if a Service member

received an apparent clean bill of health during an examination one month before deployment. He or she will be assessed again before deployment to make sure there are no new or unresolved health issues that might preclude deployment or require treatment before deployment or special considerations during deployment.

The Services' methods of evaluating their personnel for deployability are applied throughout Service members' careers. Current policy requires conducting additional Pre-Deployment Health Assessment to all Service members who are deploying. The initial stages of that assessment determine whether or not additional medical interview, examination, and testing are appropriate. Service members previously evaluated as deployable who report no changes in their health status are usually cleared for deployment by medical providers without further evaluation. This is a health care provider determination made on the basis of review of medical records, statements from the Service member, and additional medical interview, examination and testing when appropriate. We do not consider this a self-assessment, nor do not believe that self-reporting is a sufficient means to monitor the health of a soldier.

Policy requires that all deploying Service members be screened and certified by a health care provider to determine whether medical requirements have been met. Implementation of that policy varies by Service and deployment process. Implementation has not been closely monitored at the OSD level, so we cannot provide percent compliance. We are currently establishing quality assurance programs to monitor that process so we can ensure that all Service members get their health issues addressed according to the intent of policy.

Committee: House Committee on Veterans' Affairs Subcommittee on Health
Member: Rep. Simmons
Witness: Secretary Rumsfeld
Question # 9

Question: Has DoD set a timeline for conducting post-deployment physical examinations to ensure that comprehensive post-war health assessments of deployed Service members are available to the VA? Please describe the procedures the Departments are using to make these arrangements.

Answer: The February 1, 2002 Joint Staff Memorandum MCM-0006-02 emphasizes the administration of the post-deployment assessments within the five days prior to redeployment to home station or within 30 days of return. The DD Form 2796 has been expanded, and it documents that assessment. Policy ensures that the records documenting follow-up evaluations, which are to be conducted by privileged providers according to the VA/DoD Post-Deployment Health Clinical Practice Guidelines, and other follow-up health care are to be incorporated into the Service member's permanent health record, which is the standard practice. When Service members leave active duty, their records are routinely transferred to the custody of the DVA. Transfer of electronic health information at the time separation from the Department of Defense to the DVA is being done through the Federal Health Information Exchange. This data consists of demographic data, laboratory results, radiology results, military treatment facility outpatient pharmacy data, discharge summaries, and admission, and transfer information. Future enhancements will include allergy information, consult reports, and TRICARE network provider outpatient pharmacy data.

Committee: House Committee on Veterans' Affairs Subcommittee on Health
Member: Rep. Simmons
Witness: Secretary Rumsfeld
Question # 10

Question: According to Centers for Disease Control and Prevention, over the past two months health care volunteers have begun receiving the smallpox vaccine. Seven volunteers have developed cardiac-related complications, and just this week two individuals have expired from heart problems after receiving the vaccine. The Subcommittee understands that CDC officials have decided to screen out anyone diagnosed with preexisting heart conditions. In light of this situation, would you agree that real-time physical examinations involving a doctor should be conducted on every Service member prior to vaccinations?

Answer: The average age of military personnel tends to be in the early twenties. Rigorous medical history and examinations upon entrance to the military essentially preclude individuals with preexisting heart conditions from entering the Service. Individuals with functional heart murmurs (no cardiac abnormality) must undergo extensive cardiac testing prior to acceptance into the Service. Periodic health assessments along with routine health care encounters throughout the Service member's career provide opportunities for the detection of newly developing cardiac conditions. Due to the military's rigorous lifestyle and training, it is unlikely that heart conditions would go unnoticed or be overlooked.

National experts, both federal and civilian, have developed screening criteria to identify people who should be exempted from receiving smallpox vaccine due to heart conditions or cardiac risk factors. Their recommendations are reflected in the advisory committee for immunization practices smallpox vaccine screening guidelines. The Department of Defense has followed Centers for Disease Control's lead and implemented the screening guidelines. Physicians are available to evaluate potential vaccinees if questions or concerns arise regarding their risk for cardiac events.

Committee: House Committee on Veterans' Affairs Subcommittee on Health
Member: Rep. Simmons
Witness: Secretary Rumsfeld
Question # 11

Question: How would you rate the success of your current efforts to electronically monitor immunizations of deployed Service members?

Answer: I am pleased with the success we have seen so far with electronic monitoring of immunizations and encouraged by the continuing enhancements planned for the future. Each Service fields an electronic immunization tracking system that reaches medical facilities around the world. Department of Defense (DoD) and Service policies require all anthrax and smallpox vaccinations to be entered into these tracking systems. The systems feed information to the Defense Eligibility Enrollment Reporting System as a central repository from which DoD-wide reports are generated. Current capabilities and implementation vary by Service. In aggregate, current systems can effectively monitor immunization status. Several system improvements are being designed or implemented. DoD-wide solutions to immunization tracking, such as those contained within the Theater Medical Information Program and the Composite Health Care System II Program, offer tremendous promise for consistently providing high quality tracking solutions across all Services.

Questions for the Record
Honorable Rob Simmons, Chairman
Subcommittee on Health
Committee on Veterans' Affairs
March 27, 2003

Post hearing questions on Bioterrorism Research and Post Deployment Health Care for Veterans

1. Dr. Roswell, have you been contacted by local VA officials or affiliated university officials with regard to Public Law 107-287? Please provide the Subcommittee a list of those that have contacted you.

Response: Both Ron Blanck and P. K. Carlton have spoken to me about this. Ron, a former Army surgeon general, is president of the Texas College of Osteopathic Medicine. It is my understanding that P.K., who is a former Air Force surgeon general, is with Texas A & M Medical School.

2. If the appropriation ban that we discussed during our hearing were lifted, how soon could you issue a Request for Proposals and initiate the new research centers authorized under Public Law 107-287?

Response: VHA can issue a Request for Proposals 45 days after the current appropriation ban is lifted, assuming sufficient funds are made available to support the Medical Emergency Preparedness Centers (MEPCs) as authorized in Section 2 of PL 107-287.

3. Would the new emergency preparedness centers be helpful to your relationship with DoD on the other theme of today's hearing, force protections in the active duty military force? Please provide several examples.

Response: The principal mission of the MEPCs as authorized in Section 2 of PL 107-287 is to support VA's primary missions. One of VA's missions is to back-up the DoD health care system particularly in the event of a war and provide support for post-deployment health care needs. Although the MEPCs will not directly aid DoD in Force Health Protection efforts because there are too many differences between domestic and foreign battlefield conditions for the centers to play much of a role in Force Health Protection. Some of the general health education efforts developed by the centers may have applicability for the military because health care providers in both VA and DoD will have to be taught how to diagnose and treat similar biological and chemical warfare exposures. If our combat troops have health care needs arising from the use of chemical, biological, radiological or other threats to public health and safety, then an active VA program in the Medical Emergency Preparedness Centers will help DoD and our troops.

4. How many VA employees are members of the ready reserve and standby reserve? To date, how many VA employees have been called to duty in the current conflict in Iraq or to support this effort? What is your contingency plan to replace those VA employees who have been deployed?

Response: VA has 15,204 employees who are members of the ready reserve and standby reserve. During the months of December 2002 and January 2003, approximately 350 VA employees were on active duty. In February 2003 the number increased to 560, March 866 and as of June 5, 2003 to 1,022. Specific number of employees is fluid and may change daily. As of March 31, 2003, 866 VA employees had been activated or mobilized. However, VA is unable to determine if these employees were activated specifically due to the conflict in Iraq as no centralized review of specific orders takes place.

VA will ensure that sufficiently trained personnel are available at all times to provide the delivery of all benefits and services to veterans effectively and with a minimum of disruption. The Office of Personnel Management provides a wide array of authorities and staffing flexibilities that VA can use to immediately replenish our workforce, e.g., contract hiring to fill critical positions, direct hire authorities, temporary or term appointments, and reemployment of Federal retirees. In addition to these hiring flexibilities, VA has identified other staffing support that will minimize the effect of mobilization: calling in intermittent and part-time employees to work full-time; using fee basis and locum tenens arrangements, and reassignment of existing staff to maintain coverage; detailing certain employees from one VA facility to another to assist in meeting emergency response or to fill critical positions; and having certain VA employees and volunteers report to local medical centers to provide assistance.

5. War produces both physical and mental privations beyond the environmental exposures that we discussed during the hearing. Would VA be ready to deal with an infusion of thousands of new veterans with needs to work out their emotional traumas from this war, to relieve stress, to de-brief, to with the post-traumatic stress that war inevitably produces? Does the VA have the capacity and the ready expertise to do something for these new veterans? What have you done to make such preparations for returning veterans, specifically, in the VA mental health arena?

Response: The VA has the expertise and training to address the psychosocial needs of veterans who experience the psychological sequela of serving in a combat zone. The Mental Health and Readjustment Counseling Service's provide a comprehensive system of addressing the readjustment needs of veterans with the National Center for PTSD. They provide the research and educational elements of a VA system that pioneered, and considered the world leader in, the treatment of combat related trauma.

Mental Health and Readjustment Counseling Service are developing scenario planning to address differing projections of infusion of veteran mental health needs resulting from Operation Iraqi Freedom and Global War on Terrorism soldiers. Both services are working closely with Public Health and Environmental Hazards Service to monitor potential health risks in those environments, as well as, the type of combat exposure that these soldiers experience. We are working with DOD colleagues on educational programs for our clinicians and on service delivery scenarios.

Additionally, the VA has the valuable input of the Secretary's Advisory Committee on the Readjustment of War Veterans, as well as, the Under Secretary's Advisory Committee on PTSD bringing in both external and internal expertise.

6. An article earlier this week in the Washington Post indicated VA would be prepared to offer as many as 7,000 hospitals beds to DoD if needed for injured troops from this conflict. How did you reach the conclusion that you could make available one-third of your current total hospital capacity, given that you have virtually no unoccupied resources based on everything we have been hearing for the past two years?

Response: The estimate was based on the current Department of Veterans Affairs (VA) plan to support Department of Defense (DoD) under Public Law 97-174 (38 USC Section 8111A). Under this law, if requested by the Secretary of Defense, the Secretary of VA may grant a higher priority of care to active duty military personnel over all other eligible beneficiaries, except those with service-connected disabilities. The estimated beds that could be provided to DoD are therefore based on this provision of the law that allows a reordering of priorities. This does not mean that currently enrolled beneficiaries would be denied care. When the VA-DoD Contingency Plan is activated, 65 VA Medical Centers (VAMCs), designated as Primary Receiving Centers (PRCs), can be used for direct admission of active duty casualties. Capacity at these facilities to accept casualties can be created through several approaches. Examples of these approaches include: 1. Transferring care of some enrolled beneficiaries to either VAMCs that are functioning as Secondary Support Centers (SSCs) or to private sector (civilian) health care facilities; 2. Augmenting staff at PRCs with staff from SSCs; 3. Postponing elective surgeries and other non-emergent procedures; 4. Postponing leave for VA health care facility personnel. If the VA-DoD Contingency Plan is activated, the impact on currently enrolled veterans will depend upon numbers of casualties being sent to VAMCs, casualty acuity status and diagnoses, and other demands associated with health care services. Through adapting resources and patient care requirements within its integrated health care system, VA's plan is structured to minimize inconvenience to its enrolled veteran beneficiaries, ensuring that priority health care needs of beneficiaries continue to be met throughout the period during which DoD relies on VA to provide back-up medical support under the law.

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